Doncaster Integration and Better Care Fund

Narrative Plan Template 2017/19

V6 Draft

Contents

Introduction/Foreword

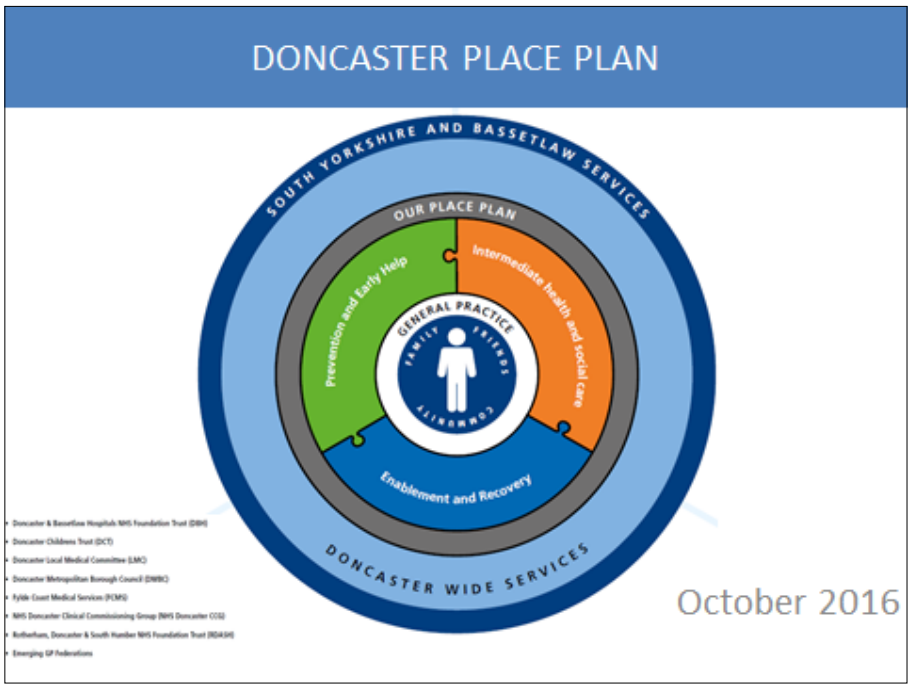
Since the last Better Care Fund Plan was developed in Doncaster, considerable work has taken place across the Doncaster Health and Social Care Community to define a future vision. This has provided greater clarity for the role of the Better Care Fund and the Improved Better Care Fund in Doncaster and the way in which integration can be locally achieved on a much greater scale. The Better Care Fund will support the transition from the old to the new, ensuring that services are transformed to meet the future needs of our population.

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

However there is a strong view that in order to transform our services to the degree required to achieve excellent and sustainable services in the future, we need to have one vision and one Plan for the whole of Doncaster. For this reason, key leaders from across health and social care in Doncaster came together during 2016 to develop the Doncaster Place Plan (the Place Plan).

This was the first time in Doncaster that we had fully articulated a shared vision across health and social care and there was significant contribution across a wide set of local organisations:

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



Local Vision and Approach for Health and Social Care Integration

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

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

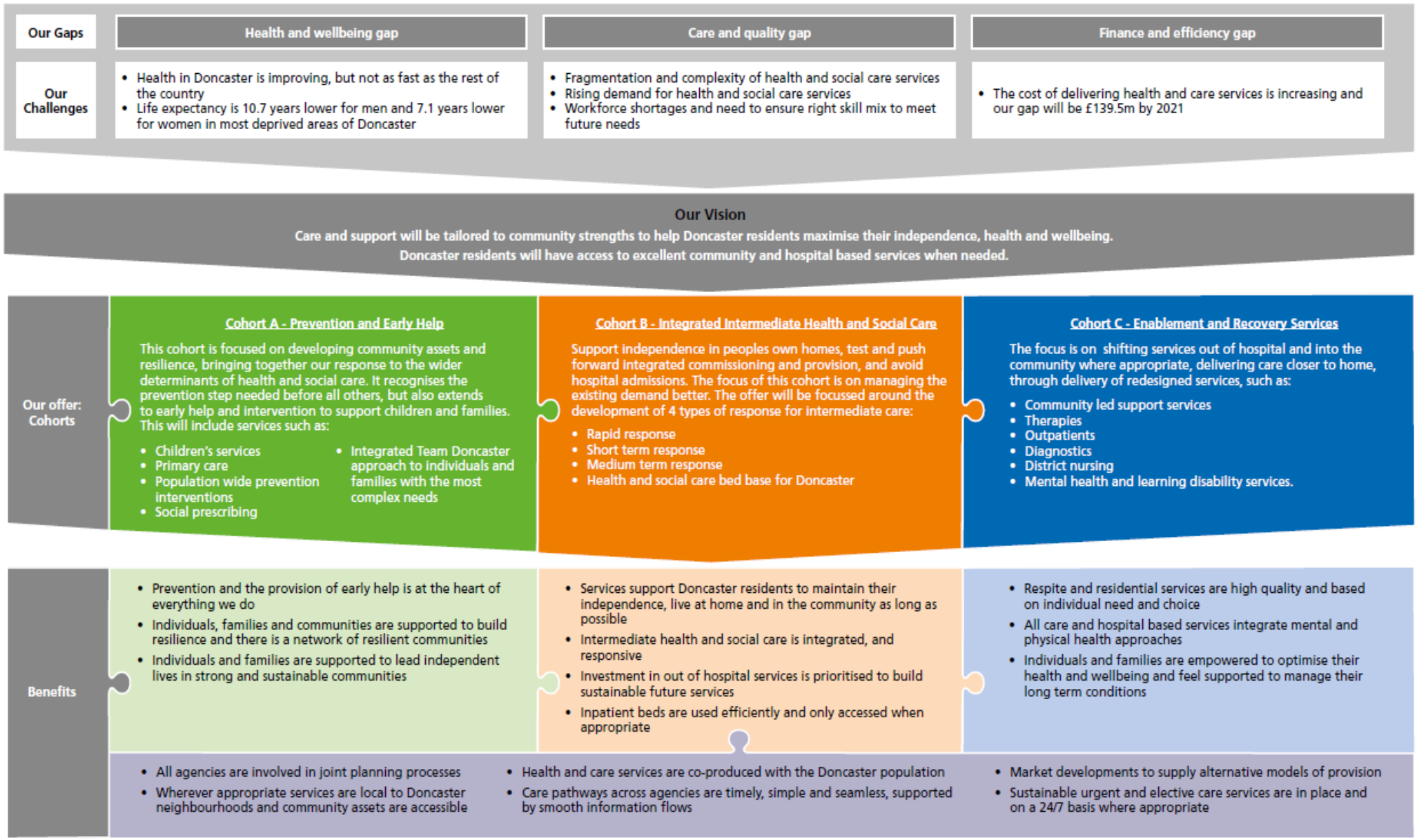
Our joint vision is:

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

In order to realise realise this vision it is recognised that Doncaster needs to develop a more integrated approach to both commissioning and provision. This was described within the Place Plan as 3 cohorts of activity, and is demonstrated in the plan on a page below.

The Better Care Fund is seen as a key enabler to undertaking the transformation pieces of work required to deliver the vision. Since the Place Plan was launched work has continued to be taken forwards, with regards to the development of joint commissioning and how providers can come together in an accountable partnership. This is described further on page 14.

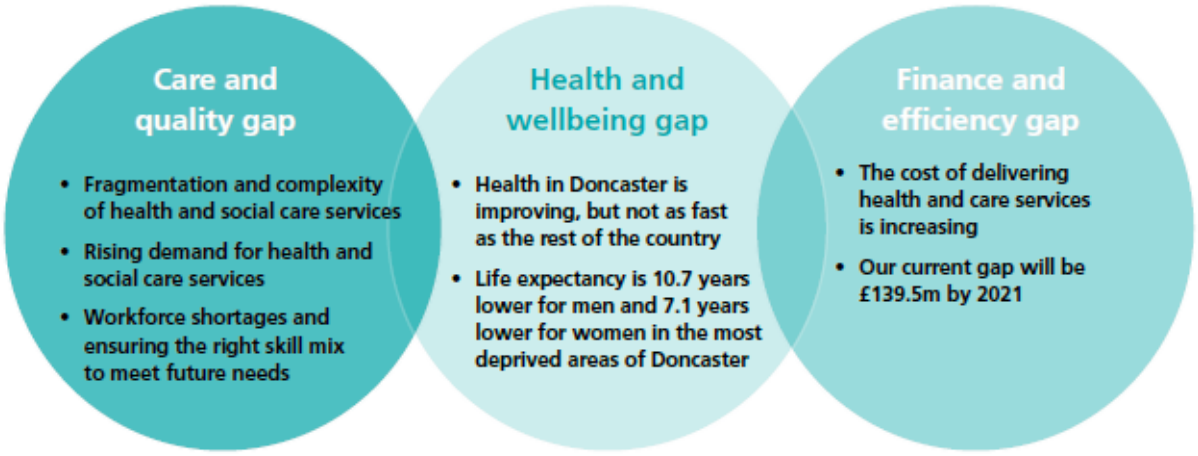
The diagram below summarises our Place Plan – how our joint 'cohorts' will help us address our challenges and achieve our vision.



Background, Context and Evidence Base for the Plan

The Doncaster Place Plan describes the case for change in Doncaster.

Key Challenges:



If we did nothing…

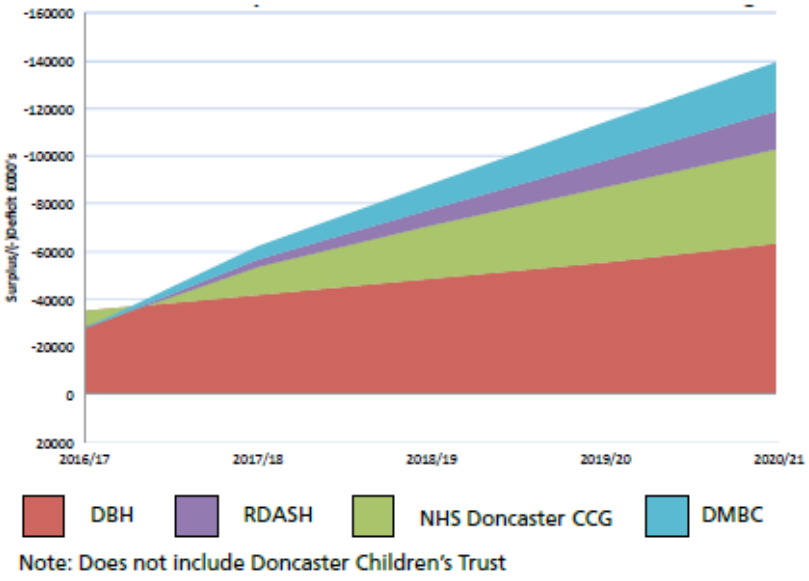
Whilst our Place Based Plan is aimed at improving the health and wellbeing, and the quality of care for our Doncaster residents, there is an ever increasing pressure to do this within the financial resources available to our Organisations. The Better Care Fund will help to support our transformation work, but future services will still need to be more cost efficient and achieve better use of the "Doncaster pound".

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

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

Locally the "do nothing" scenario is demonstrated below. The total financial gap is combines potential provider deficits, and the individual financial income and expenditure gaps of the CCG and the Local Authority commissioning budgets. It is clear that the Place Plan, supported by the Better Care Fund, must be aimed at spending the "Doncaster pound" more effectively.

Summary of Doncaster Financial Position – Do Nothing

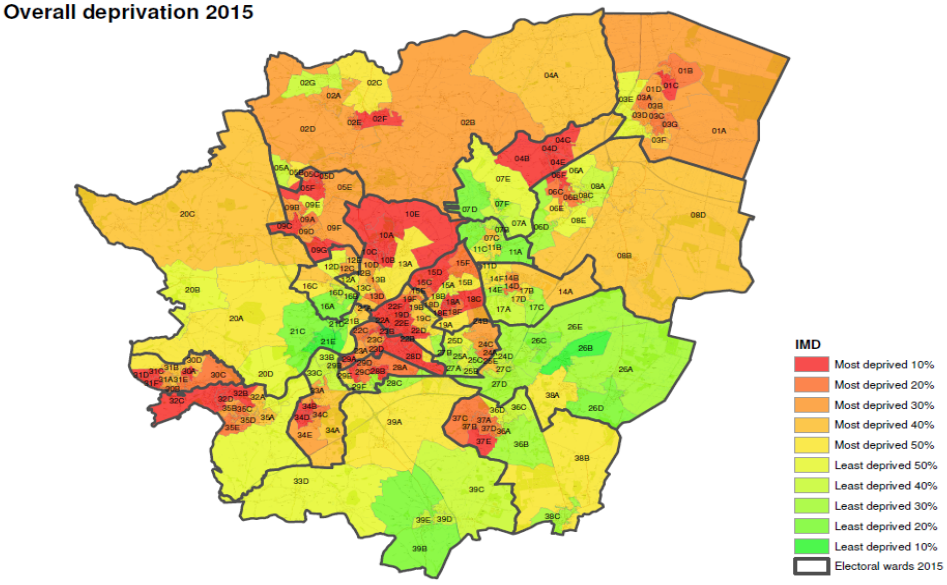


Note: Does not include Doncaster Children's Trust

Understanding Current Need

1.1. The current need for health and social care within Doncaster has not changed significantly from that outlined in the previous 2016/17 plan. In summary:

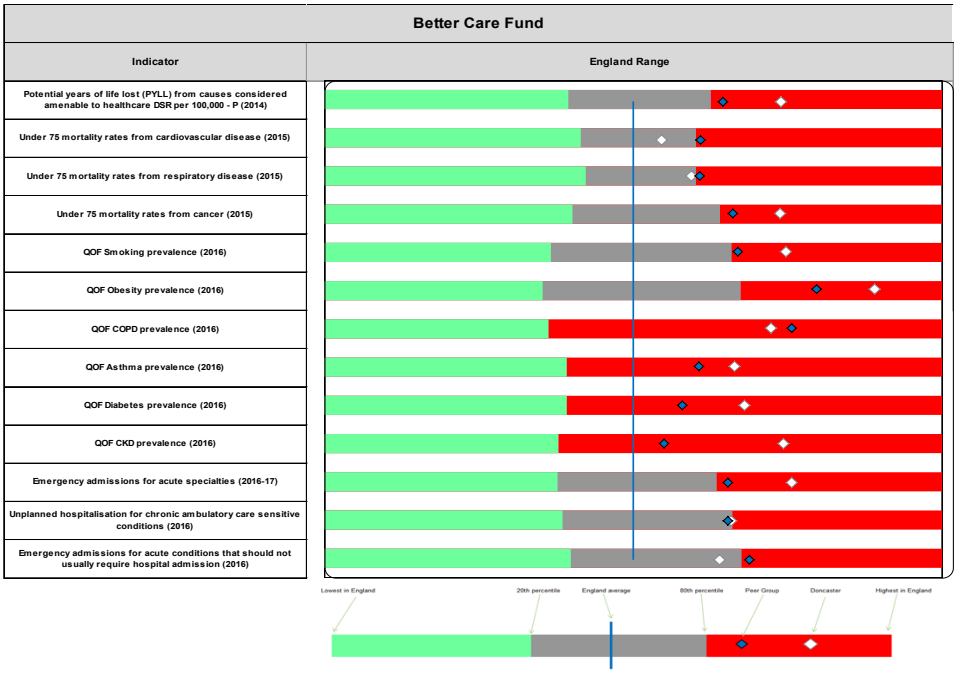
1.2. The total resident population of Doncaster is 304,813 (ONS mid-2015 population estimate). The population registered with a NHS Doncaster CCG GP is 317,514 (as at 1st Apr 2017). This includes a wider geography than just the main conurbation around the town centre, ranging from urban to rural. Doncaster's Index of Multiple Deprivation (IMD) in 2015 was 29.05 which is 42nd highest out of 326 local authority areas in England and 20.62% of the Lower Super Output Areas (LSOA) in Doncaster are in the 10% most deprived LSOAs in England. Doncaster is the 2nd most deprived area in the Sheffield City Region and the 5th most deprived area in the Yorkshire and Humber Region



1.3. The Doncaster Joint Strategic Needs Assessment (JSNA) and locally produced benchmarking, using data from HSCIC, was used by the partnership to underpin the development of the BCF plan. The majority of the themes within this remain largely unchanged:

- Overall Health and Wellbeing is improving in Doncaster for both men and women.
- However, too many people still experience poor health with too many dying prematurely (i.e. before the age of 75).
- Diseases such as cancer, cardiovascular disease, liver disease and respiratory diseases account for between 80-90% of all preventable deaths, although due to action taken to increase work around cancer awareness, early identification and treatment over the past 2 years there have been a number of improvements around cancer.
- In general, lifestyles including smoking, physical activity and nutrition are less healthy than the rest of the country. This is true for children as well as adults and Doncaster has the 2nd highest rate in England of adults that carry excess weight (overweight or obese) at 74%.
- According to the results of the most recent GP Patient Survey published by NHS England in July 2016, 66% of Doncaster registered patients had enough support from local services or organisations to help manage long-term health condition(s) in the last 6 months. Doncaster ranks 32nd out of the 209 CCGs for whom results were published. The national average was 63.11% and the Yorkshire and Humber average was 64.7%.
- 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. Dementia remains a priority for Doncaster and some key outcomes have already been achieved, including a significant increase in the diagnosis rate and the number of Dementia Friends, fewer people with dementia are being admitted to hospital and in the main their lengths of stay are reducing.
- Where people live, as well as education, housing, work, crime and the environment all contribute to health and wellbeing. The year-on-year increase in overall crime continues for the fourth consecutive year with a 7% increase from 2014 to 2015. Anti-Social Behaviour has reduced slightly over recent years with a 2% drop 2014 to 2015, followed by a 5% increase in the first half of 2016. More new homes are being built in Doncaster with delivery at its highest for 15 years, and all Council housing now meets the Government's Decency standards.

1.4. The above factors are demonstrated in the spine chart below, which sets these issues in the context of the Doncaster peer group and England rates, using the latest available data.



The 2017/18 Plan

Significant progress has been made in some areas of the 2016/17 Better Care Fund Plan, such as intermediate care, and the Fund is now also being used to support the transition from the former approach to the new. As such the Better Care fund plan in itself is a plan in transition for 2017/18 – comprised of the existing schemes that need to continue, and a range of new schemes that are in development to support the integrated future vision.

The following section describes the transition from the 2016/17 plan to the plan for 2017/18 and beyond. It is important to note that whilst the landscape surrounding the plan is developing in Doncaster, the commitment to the local BCF principles remains:

- Schemes should demonstrate commissioning of health and social care services in a joined-up manner.
- Engagement and co-production with wider stakeholders including commissioners, providers, service users, carers and partners must be part of the scheme or pilot development.
- Schemes must support the national requirements
- Schemes must be able to demonstrate how they are:
    - Person-centred
    - Building on individuals strengths and promoting self-care
    - Focussed on individuals developing/ maintaining their independence
    - Holistic in their approach to physical and mental health and social care effectively utilising communities and their resources
- Scheme must evolve into new ways of working, achieving efficiencies/ sustainability and improved patient experience / quality of care.

The table below summarises the schemes, set against the newly defined national scheme types and mapped to the Place Plan cohorts. Within each scheme there are a range of plans. These schemes represent both the original work for the Better Care Fund, and the future work, as despite continuing to deliver changes and improvements in line with the original aspirations of the Doncaster BCF plan, it has been recognised through the Place Plan that we need to move further, faster and in different ways. Looking forward there are a new stream of actions currently underway and work is expected to move at pace during 2017/18 and beyond. The current progress with this work is also summarised below.

As demonstrated in the table below, there are a range of plans that are grouped into a number of broad schemes:

- Upstream Prevention
- Building Community Capacity
- Neighbourhood Delivery
- Aids and Adaptations
- Preventing Admissions
- Intermediate Care
- Mental Health & LD
- Dementia Services
- Improving Transfers of Care and Supporting Discharges
- Integration Enablers

Scheme Category	Place Plan Cohort	Maintenance of spending on Social Care	Investment in NHS Commissioned Out of Hospital Services	HIC Managing Transfers of Care	Reducing admissions into long term care	Reducing non-elective admissions into hospital	Increasing effectiveness of reablement	Reducing delayed transfer of care
Aids and Adaptations	A	✓			✓		✓	
Community Capacity/Assets	A	✓			✓			
Dementia	C	✓	✓		✓	✓		
Discharges	B		✓	✓				✓
Enablers	A, B C	✓	✓	✓	✓	✓	✓	✓
Intermediate Care	B		✓			✓	✓	
Mental Health	C		✓		✓	✓		
Neighbourhood delivery	C		✓		✓			✓
Prevention	A	✓			✓	✓		

Upstream Prevention

This scheme is targeted at specific cohorts aiming to prevent health issues before they occur. For example, the Move More programme offers accessible exercise classes each week to people over 50 encouraging them to become more active.

Building Community Capacity

The Doncaster Place Plan puts a significant emphasis on strengthening delivery by the community for the community. This will help to ensure future community resilience and maximise the strengths already in communities. It includes a broad range of activities from supporting small scale interventions such as dig it Denaby to borough wide approaches that capitalise on existing community strengths such community led support which will base interventions on the development of 'three conversations.

Neighbour Hood Delivery

This scheme seeks to ensure that services are delivered locally and tailored to neighbourhood needs. This approach will develop more rapidly as the neighbourhood profile and customer insight work detailed on page 13 informs the future services commissioned via accountable care partnership approach as described on page 14.

Aids and Adaptations

The DFG continues to be spent in accordance with requirements. Assistive technology is used within care home and residential settings and is key to the delivery of successful prevention and reduced cost of care packages. Currently equipment is supplied and monitored through the STEPs and Heart service, in the future we expect to maximise use of assistive technology in both social care and health provision.

Intermediate Care

Intermediate care is at the heart of supporting people to avoid hospital admission through remaining at home or in an alternative safe environment.

Through locally developed plans access to Intermediate Care will be simpler, more responsive, with the majority of services being in the Community. Core projects to support these plans are detailed in Appendix A.

Mental Health & LD

Currently our learning and physical disability service is a traditional reactive service, work is underway to modernise and transform to a proactive, creative and person centre service so that people have more choice and control over how they live their lives and the type of support provided for them. This will include moving away from residential care into supported living, shared lives and in some cases independent living. Mental Health initiatives such as Doncaster Mind and Changing Lives are key to our partnership approach to mental health.

Dementia Services

Nationally and locally an aging population has made dementia one of our key priorities in terms of how we approach the challenges this disease presents. There are a number of initiatives in train such as the Admiral Service which provides care for people diagnosed with dementia and their carers, further details are shown at Appendix A.

Discharges- please see section on Delayed Transfers of Care

Improved Better Care Fund (iBCF) – agreed plan shown at Appendix B

The IBCF is being used to supplement existing plans, in particular supporting the national requirement**s:**

a) Meeting adult social care need

b) Reducing pressure on NHS, including supporting more people to be discharged from hospital when ready

c) Ensuring local social care provider market is supported.

The Doncaster plan for the iBCF will complement the plan detailed above as detailed in the table below:

Meeting Adult Social Care Need:
Funding increased demands due to demographics including children transitioning to adults as well as increased direct payment and individual budgets, which support choice and the move away from traditional high cost placements in care.
Residential Short Stay - the demand for this service has increased as more individuals are supported to live at home, reducing the numbers in residential care and hospital. There is also a specific pressure regarding a small number of high cost Learning Disability service users who have to remain in short stay for extended periods of time because of lack of suitable alternative provision.
Reducing saving proposals whilst alternative options and practices are introduced as part of the transformation programme - supporting more people to live at home reducing residential care pressure and increasing availability of residential care for people leaving hospital services.
Funding for additional Extra Care Capacity
DoLS/Safeguarding Adults Hub – funding to support increased demand.
Support for projects specifically targeting vulnerable adults, which will help reduce call on high cost health and social care services.
Reducing Pressure on the NHS
Funding the increased provision of community equipment enabling more people to remain in their own homes.
Funding for investment in technology including more assistive technology
Ensuring local social care provider market is supported
Delayed transfers of Care (DTOCs) – estimated funding to address outcomes due from joint review with the LA and CCG, recognising some further investment may be required.
Funding the impact of the National Living Wage on the cost of sleep in night for supported living providers.
Residential fees - as part of the negotiations for the 2017/18 fee a cost validation exercise took place that supported a significant increase in the rates paid to providers. The figure includes £0.3m for the CCG for 2017/18 to enable the work on the Care Home Strategy to be completed.
Funding further support for the provider market for estimated increases in retendered contracts.

Integration Enablers - EY

There is a long history of partnership working across the Health and Social Care system within Doncaster to achieve improved outcomes for local people. There is also a strong view that in order to transform services to the level required to achieve excellent services in the future, there is a need to develop one vision and one plan for the whole of Doncaster that is owned and supported by key partners across the health and social care system. In order to take this work forward a procurement exercise was undertaken to secure external support from an organisation with the appropriate skills and knowledge in this emerging area of health and social care and consultants EY were appointed to support us with this work. As a result, a number of areas have been highlighted as areas of opportunity to test the new ways of working in Doncaster from a joint commissioning and a joint provision perspective. Work is at varying stages across these work streams and at this point not all areas are supported by the Better Care Fund, the model shown on page 14 will support transition.

Detailed information about the progress of each of these schemes and next steps can be found at Appendix A

Delivering the Plan for Integration

There are two fundamental building blocks to delivering the plan for integration in Doncaster:

- Development of neighbourhood profiles to enable service delivery to be tailored in response to local needs
- Development of Programme Management approach and supporting governance to facilitate the development of joint commissioning and an accountable care system approach

Work is progressing in Doncaster on both these elements, supported by the Better Care Fund as the work develops. This development is running alongside existing schemes to ensure that the momentum is maintained as the new landscape is determined.

Neighbourhood Profiles

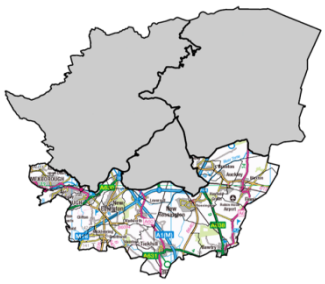
Building on the original work and population segmentation for the Better Care Fund Plan, work has been underway to develop Neighbourhood Profiles, in support of the fundamental premise of the Place Plan that services need to be delivered locally where possible, and tailored to the needs of that neighbourhood.

Stakeholders have agreed to divide Doncaster into four neighbourhoods to enable services to be tailored to local needs and delivered locally where appropriate. To assess the respective needs profiles for each of the four neighbourhoods have been produced (see supporting documents). The neighbourhoods follow the natural geographic pattern of Doncaster and are already the basis of service provision for many of social and community care services.

North

East

South



Central

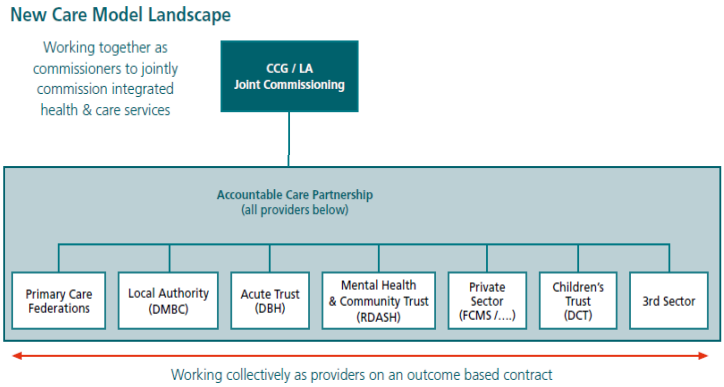
In addition to developing the neighbourhood profiles, we have also recognised that it is essential to have a rich understanding of people actions and motivations, so that we are able to work with the grain of people's lives. There are a number of agencies who focus on the delivery of either qualitative or quantitative insight into residents, but we know that we require a mixture of these skills. Although local ethnographic research has been recently commissioned that gives us some insights, we need to develop this to a much greater extent.

As a result some Customer Insight work has just been commissioned and commenced at the end of August 2017. This will see a blended approach to the work, utilising resident surveys and interviews, focus groups with staff at a local level, with a real focus on 'getting out there' to the places where people live. It will also help us to develop a platform for sustained engagement and meaningful conversations with residents. The approach will be two pronged, with one strand seeking to listen and better understand some key issues to do with residents health and well-being across the four neighbourhoods, and the other generating interest in public health through community outreach using a range of different platforms (radio, print, media). The combination of these two would help us to create a typology of Doncaster people from the core themes/issues/ personas, and provide an insight into the typologies, barriers and approaches to overcome them. This work is expected to complete in? [Confirm].

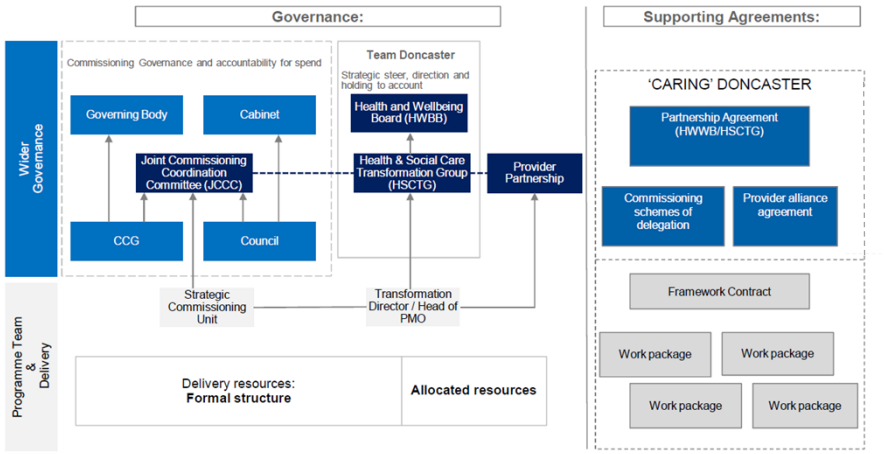
Programme Management and Associated Governance

The Doncaster Health and Social Care Community are on a journey towards integration and this plan captures that journey and future intention at a point in time. The Health and Social Care Community have engaged a Strategic Partner to help take forward the journey to an integrated system. This is currently at a pivotal point, whereby there is a commitment to develop initial partnership agreements and supporting governance arrangements from October 2017 with full implementation from April 2018. Initially this will be for a number of areas of opportunity as described below, but over time it is expected that these will be expanded. The Better Care Fund, in line with the principle of supporting transformation, is an integral part of this.

The current Doncaster vision of an integrated system is shown below.



The governance behind this model is currently being established, building on the Joint Commissioning Committee that is already in place to oversee the Better Care Fund. The latest model is shown below:



It is expected that a shadow for of this governance model will be in place from October 2017 with respect to the follow areas of opportunity:

- Urgent & Emergency Care
- Complex Lives
- Intermediate Care
- Starting Well (1001 Days)
- Vulnerable Adolescents (Tier 4 Specialist Services)
- Dermatology

These areas will test out the emerging operating model in Doncaster.

Risk –

Tracy to look at guidance on finance risk share

Our vision and approach centres largely on the place plan as referenced above. Around this a robust programme management and governance arrangement using the Managing Successful Programmes methodology is currently being developed. This will ensure frequent, high profile and problem solving focused accountability routines which will adopt best practice programme management and delivery management techniques. Integral to this is the use of risk registers and risk profiling techniques using the Covalent online tool to enable stakeholders to see, own, track and manage key risks. Key risks will be identified and proactively managed through the programme performance and accountability routines. This will include risks associated with the use of BCF to support improved outcomes, service transformation and integration. This approach has been supported by the Team Doncaster Strategic Partnership and the Council's senior executive and political leadership.

Overview of Funding Contributions

The agreed IBCF can be found at Appendix B

Programme Governance-

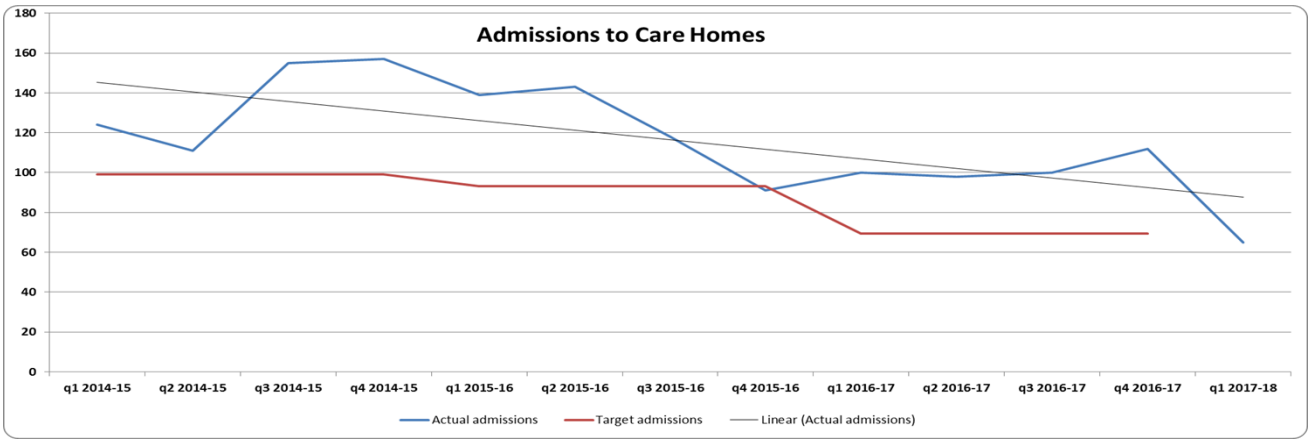
Robust governance of the BCF and IBCF is essential. Current arrangements include the Transformation Co-ordination Group scrutinising all business case proposals and applying confirm and challenge techniques to these, recommendations are then made to the Joint Commissioning Co-ordination Group of which the Chief Executives of both DMBC and DCGG are members. Governance will be strengthened through the developing risk management methodologies described above and the new Adults Health and Wellbeing performance management framework which will be launched towards the end of the year.

National Metrics

The section below sets out the ambition in Doncaster against the national requirements. The actions to ensure delivery of these are set out in section Appendix A and specifically in relation to DTOC on pages 17 – 19.

Residential Admissions

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes.

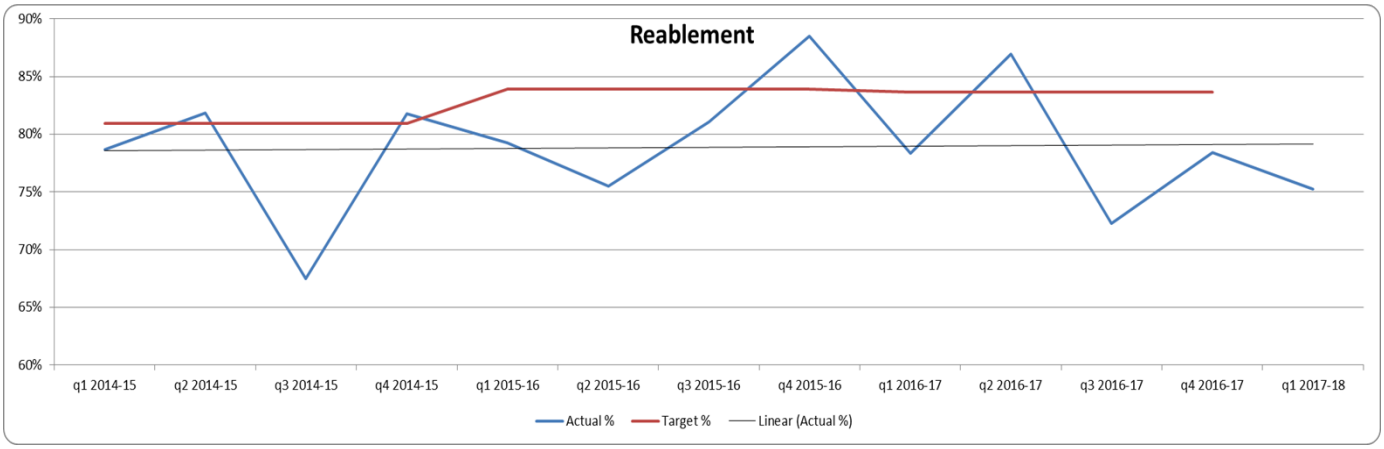


In 2016-17 410 people aged 65+ were admitted to residential and nursing care homes in Doncaster. The numerator figures indicated for 17/18 and 18/19 below are consistent with Doncaster plans and are anticipated to reduce the overall numbers of over 65s in residential care:

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	890.1	487.5	641.3	568.4
	Numerator	500	278	371	334
	Denominator	56,173	57,029	57,855	58,761

Reablement

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services.



In 2016-17 the proportion for Doncaster was 78.7%. The BCF statistical significance calculator has been used to set the 2017-18 and 2018-19 targets below:

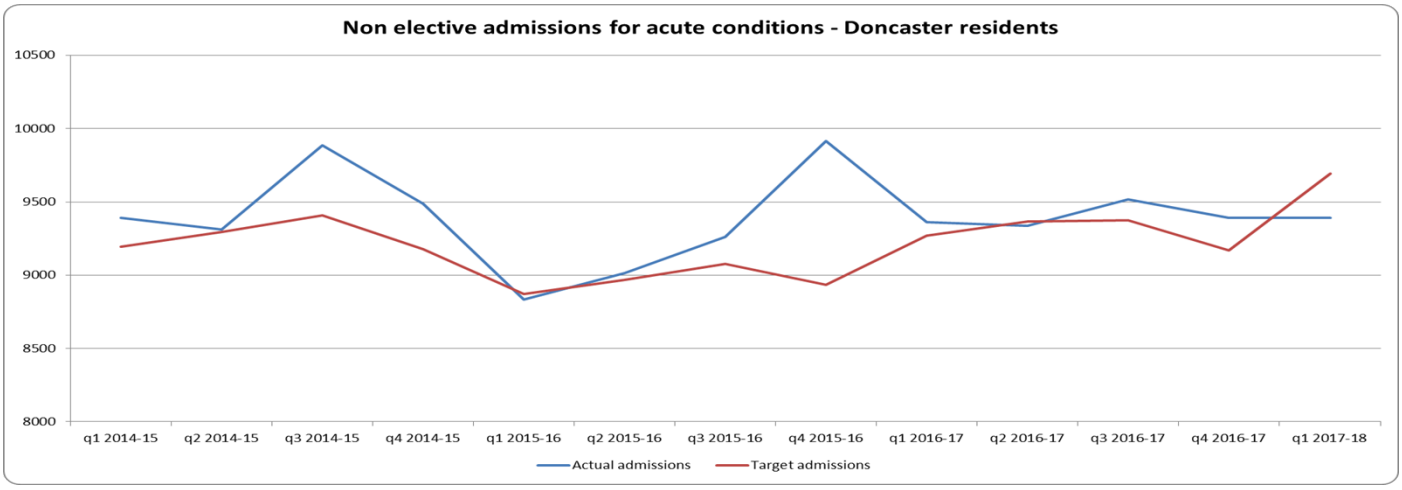
		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	81.9%	83.7%	82.0%	85.2%
	Numerator	140	569	617	641
	Denominator	171	680	752	752

Non-elective Admissions to Hospital

Doncaster CCG's operational plan for non-elective admissions in 2017-18 is 39140 which is a 3.55% increase on 2016-17. There is a planned 3.91% reduction in 2018-19 to 37611 to reflect the impact of transformation work which will help maintain people at home and therefore reduce emergency admissions and A&E attendances.

The BCF totals below are slightly due to being adjusted to a Doncaster resident basis whereas CCG plans are on a registered Practice basis.

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Total 17/18	Total 18/19
9,694	9,694	9,691	9,693	9,322	9,322	9,319	9,320	38,773	37,284



Delayed Transfers of Care

With regards to Delayed Transfers of Care (DTOCs) a system wide Delayed Transfers of Care workshop was held in May 2017. This was in response to the number of reported delays increasing and pressures that were felt within the system with regards to domiciliary care. The workshop focussed on both the counting of DTOCs and actions required system wide to ensure that the number of delays reduces during 2017/18.

During the workshop the High Impact Change Model[i] changes and action planning template were used to guide the discussion. The workshop did not encompass all 8 changes due to time restrictions. Throughout the workshop actions were captured on a template and at the end nominated organisational leads to take the work forwards were identified.

Identified Actions

Following the workshop the nominated leads have met to flesh out some of the detail behind the actions captured on the day. The group also discussed a simple, local framework to guide thinking through the patient journey and ensure that all stages have are being addressed:

On Admission…On the Ward…On Transfer…Going Home

Through this process it has become clear that there were a considerable number of actions suggested during the workshop and that these need to be prioritised. The detailed action plan is attached at appendix A.

In order to prioritise the actions the local framework was used to ensure that each stage of patients' pathways are considered. The resulting priorities are as follows:

- Estimated Discharge Date (EDD)
- Ticket Home
- Transport
- Medication
- Social Care Interim
- Working with others
- Trusted Assessor

The priorities have also been mapped across to the national 8 High Impact Changes to ensure that these considerations are also taken into account:

Figure 1:

Pathway Point		High Impact Change	Priority
On Admission	→	Early Discharge Planning	Estimated Date of Discharge
On Ward	→	Systems to monitor patient flow	Ticket Home
		MDT approach	Medication
		7 day services	
On Transfer	→	Discharge to assess	Transport time
		Trusted assessor	Trusted assessor
Going Home	→	Focus on choice	Social care interim
		Enhancing care in care homes	Working with others

Next Steps:

The timescales for the identified priorities have been agreed, as have the leads and ways for taking each priority forward. This is detailed in figure 4 below. A key part of the action plan will be to test the system during System Perfect Week – this will provide a live opportunity to understand and resolve system blockages.

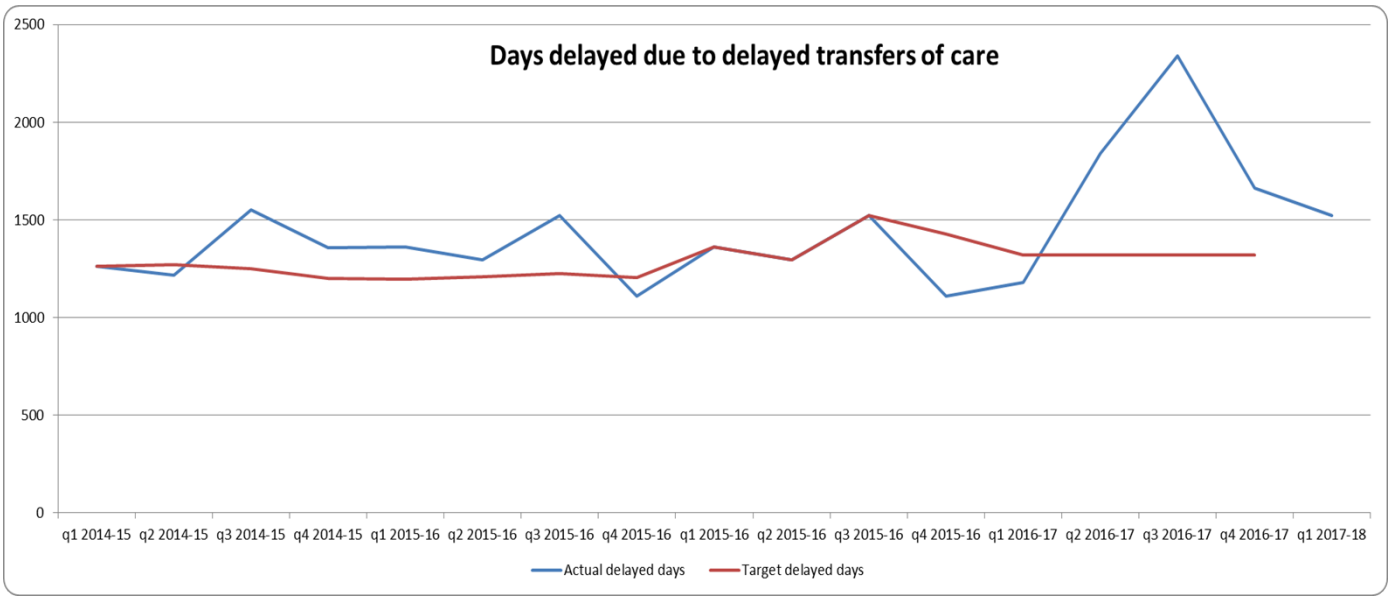
Priority	Lead	Timescale	Action
EDD	DBTH	***Immediate:*** Initial testing over summer ***Medium term:*** wider role out during Autumn/ Winter	Focus on implementing EDD throughout DBTH; initial focus on electives using LOS data already available
Ticket Home	DBTH	***Short term***: System Perfect to be used to test essential items; implementation post System Perfect	Outline ticket home already available; implementation to be delayed until System Perfect findings can be incorporated. 4 key questions to be used during System Perfect for each patient: • What is going to happen today • What is going to happen tomorrow • How well does the patient need to be before they can leave hospital • When can they expect to leave hospital
Medication	DCCG	***Immediate:*** work already commenced	Mapping to capture common issues on patient transfer, including medication, and determine actions to test during System Perfect
Transport time	DCCG	***Short Term***: September, in line with new contract commencement	Time of day for patient transport to be tested during System Perfect – ie earlier in day
Trusted assessor	RDASH	***Medium Term:*** Link to discharge QCUIN	Link to discharge CQUIN
Social care interim	DMBC	***Immediate***: development of requirements building on models elsewhere	Identify range of options and scope for social care interim Commission social care interim
Working with others	DCCG	***Immediate***: identification of wider opportunities to commence during summer	Identification of opportunities, commencing with social prescribing and housing

NHS England expects national daily delays to reduce to the following by November 2017:

NHS attributable delays	5.44
Adult social care attributable delays	6.31
Jointly attributable delays	5.57

During 2017 Doncaster has performed in line with national expectations and this is reflected in the overall target of 7.1 days. During this period Doncaster was below the expected target rates for NHS and Jointly attributable delays so the BCF trajectory for the period July 2017 to March 2019 is as per the national expectations. Doncaster was however above the expected target rate for delays attributable to social care and therefore the BCF trajectory for social care attributable delays is a linear improvement from the actual rate to the expected rate in November 2017 and beyond.

		16-17 Actuals				17-18 plans				18-19 plans			
		Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	484.6	767.0	975.4	753.2	632.6	694.5	652.2	636.4	643.3	650.4	650.4	635.5
	Numerator (total)	1,163	1,841	2,341	1,811	1,521	1,670	1,568	1,532	1,549	1,566	1,566	1,532
	Denominator	240,015	240,015	240,015	240,441	240,441	240,441	240,441	240,760	240,760	240,760	240,760	241,043



Approval and Sign Off

Local Authority	**Doncaster Metropolitan Borough Council**
Clinical Commissioning Groups	**NHS Doncaster Clinical Commissioning Group**
Boundary Differences	Doncaster Health and Social Care boundaries are coterminous. However the GP registered population includes some people who reside in another LA area. The Doncaster Model will accommodate these boundary differences
Date on Health and Wellbeing Board agenda	
Minimum required value of Better Care Fund pooled budget: 2017/18	
Total agreed value of pooled budget: 2017/18	

Signed on behalf NHS of Doncaster Clinical Commissioning Group	
By	**Jackie Pederson**
Position	**Chief Operating Officer**
Date	

Signed on behalf of Doncaster Metropolitan Borough Council	
By	**Damian Allen**
Position	**Director for Adults, Health and Wellbeing**
Date	

Signed on behalf of Doncaster Health and Wellbeing Board	
By	**Cllr Rachel Blake**
Position	**Chair of Health and Wellbeing Board**
Date	

Related Documentation

Needs updating – Rob – to update with all new docs from this year / Emma for CCG

Document or information title	Synopsis and links
Doncaster Health and Wellbeing Strategy http://www.teamdoncaster.org.uk/Images/Health%20%26%20Wellbeing%20Strategy%202015_Consultation%20v1_tcm33-111125.pdf	The strategy has been recently refreshed and sets out the priorities for Doncaster's Health and Wellbeing Board and addresses four key themes: • Wellbeing • Health and social care transformation • Five areas of focus: alcohol, obesity, families, dementia, mental health • Reducing health inequalities
NHS Doncaster CCG **Moving forward, getting better** **Five year commissioning strategy: 2014/15 - 2018/19** http://www.doncasterccg.nhs.uk/wp-content/uploads/2014/04/5-Year-Commissioning-strategy.pdf	In November 2015, NHS Doncaster CCG reviewed and agreed their commissioning ambitions for Health and Wellbeing in Doncaster over the next 5 years. The refreshed ambitions have been developed from those already set by NHS Doncaster CCG in the current five year commissioning strategy, *Moving forward, getting better, Five Year Commissioning Strategy, 2014/15 – 2018/19*, which was developed with local partners and patients. The strategy also demonstrates how NHS Doncaster CCG plans to achieve their vision through a number of transformational programmes and outcome focussed delivery plans, which again have been refreshed. These can be provided if required.
South Yorkshire and Bassetlaw Sustainability and Transformation Plan 2016 – 2021  SYB STP Summary Submission 15th April	This is currently under development across the South Yorkshire and Bassetlaw footprint. The first submitted draft is attached and further updates can be provided if required.
Doncaster Metropolitan Borough Council Adults, Health and Wellbeing Transformation Programme  The Adults Health and Wellbeing Transf	This report sets out the wider context of increased ageing population and reduced resources within which Adults, Health and Wellbeing are striving to transform. This outlines the current position, vision and outcomes and sets out the overall planned delivery including specific targets for immediate business improvement. The transformation work is being developed in partnership and BCF plays a key role in this.
Joint Strategic Needs Assessment (JSNA) **The JSNA provides an overarching**	The latest JSNA to be published is the 2014 JSNA. It made the following recommendations to the Health and Wellbeing Board:

assessment of need across the Borough. **The most recent versions are available at http://www.teamdoncaster.org.uk/Images/Doncaster%20JSNA%202014_tcm33-110466.pdf**	1. Maintain a focus on dementia. 2. Address the impact of child poverty and focus on improving breastfeeding rates especially at 6-8 weeks and reducing maternal smoking. 3. Support efforts to improve attendance at school. 4. Address the obesity epidemic in Doncaster. 5. Address the high levels of smoking in the borough especially in groups such as routine and manual occupations. 6. Maintain a focus on lung cancer and cancer generally - smoking and obesity are major contributories to cancer. 7. Increase the numbers of people who are physically active. 8. Support efforts to increase volunteering. 9. Support efforts to improve the quality of peoples living accommodation. 10. Look at how Doncaster's green space resources and be best utilised to improve health and wellbeing. 11. Ensure carers are supported and able to maintain their own wellbeing. 12. Support efforts to improve education and skills.

[i] High Impact Change Model, Managing Transfers of Care between Hospital and Home, Local Government Association, April 2017