Better Care Fund planning template – Part 1- Second Cut

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Doncaster Borough Council**
Clinical Commissioning Groups	**Doncaster NHS 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 agreed at Health and Well-Being Board:	**01/04/2014**
Date submitted:	**01/04/2014**
Minimum required value of ITF pooled budget: 2014/15 (£'000's)	**£0.00**
2015/16	**£24,163**
Total agreed value of pooled budget: 2014/15 £'000's	**£0.00**
2015/16	**£24,163**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Chris Stainforth
Position	Chief Operating Officer
Date	02/04/2014
Signature	

Signed on behalf of the Council	
By Director of Public Health on behalf of Joan Beck, Director of Adults and Communities	Dr Tony Baxter
Date	02/04/2014
Signature	

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Patricia Knight
Date	02/04/2014
Signature	

Summary of new additions to the Doncaster Better Care Fund Plan - Second Cut

(Additional information is provided in blue text)

1a) Service provider engagement
Further detail of provider engagement in the development and delivery of the Better Care Fund, including draft operational plans for key health providers.

b) Patient, service user and public engagement
Further detail on how we have developed a formal structure for service user and public engagement, including BCF engagement plan.

2a) Vision for health and care services
Further detail on the Doncaster BCF 2014-16 scheme plan, including the response to the care bill and protecting mental health services.

b) Aims and objectives
Further detail on how we will describe the changes we want to see and how we will measure the impact of those changes through our academic partnership approach.

c) Description of planned changes
Further detail of scheme areas including duties under the Care Bill - includes a first draft work plan appendix for April-Dec 2016.

d) Impact on Acute Sector
Further detail on the outcome of dialogue with acute and key providers, including appendices on operational plans which reflect BCF objectives.

e) Governance
Further detail on how BCF will be governed and the links to wider team Doncaster and Stronger Communities' governance structure.

3a) Protecting Social care
Further detail on how we intend to maintain and improve our services in Social Care and supporting Independent Living.

b) Risks
Further detail on the risks identified jointly by BCF partners and the mitigation outline to manage those risks.

c) Service provider engagement

Please describe how Health and Social Care providers have been involved in the development of this plan, and the extent to which they are party to it.

Commissioner and provider partnership and joint working has made significant progress in Doncaster in recent years. The Doncaster Health and Well Being Board has promoted the development of partnership groups, joint working, integrated commissioning and shared investment of resources. Providers are integral to the development of Doncaster's strategic priorities and have significant involvement through Health and Well Being Board governance arrangements in the development of this first cut plan, headline themes for future integrated working and the ambition and vision for the overall programme.

There is a strong shared ethos and value base from which to progress the Better Care Fund plan that is underpinned by a co-production approach to market shaping and service development. Doncaster has developed a regional best practice market position statement built on a live internet portal which is refreshed according to changes in market demand. This portal was co-produced with local providers.

Strong Chief Executive understanding of the Better Care Fund across all agencies, strategic buy into its principles, understanding of the 'simple model' and ownership of priority outcomes, are key success criteria in developing the Doncaster BCF. With one council, one CCG and one acute provider, Doncaster has all the ingredients to deliver a simple but effective plan successfully. In 2013 Doncaster Council and its partners also launched a corporate charter which forged the way for a new concept of 'Team Doncaster'. To meet Doncaster's priorities there is a real need for change in the nature and relationship between public services and local citizens; to develop a true partnership with businesses and voluntary organisations where people in Doncaster are more effectively empowered to make a real difference to the place where they live. This is the ethos of the "Team Doncaster approach"

During February and March 2014, a number of provider conversations have taken place to strengthen the Doncaster BCF plan, including a Doncaster Health and Well Being Board Workshop, which has resulted in more detail in the Short term, Long Term and Communiversal theme plans, (see appendix 1 – The Doncaster Better Care Fund Plan) defined more clearly the benefits and risks (see risks section page 31) and outlined the next steps in strategic leadership of the programme. The First Joint Strategic Commissioning Forum, jointly chaired by the Chief Executives of Doncaster Council and the CCG, will be held on May 8th 2014. This first meeting will agree the programme priorities and set the mandate for the strategic scope and intent of 2014/15 schemes.

As a result of this event and further intensive dialogue over the past 6 weeks, the changes and challenges that BCF will bring, are consistently highlighted in key provider plans and strategies.

The Doncaster & Bassetlaw Hospitals NHS Foundation Trust Operational Plan for 2014-16 clearly recognises the Better Care Fund as an opportunity to build on existing integration achievements, such as the Integrated Hospital Discharge Pathway and to develop new ways of working to meet BCF ambitions.

> *'We have existing strong relationships within the local health economy including CCGs, other providers and local authorities in the Doncaster & Bassetlaw area. We have a*

history of working together to provide integrated services consistent with the national conditions identified in the Better Care Fund guidance. An example of this is our Doncaster Rapid Access Process Team (RAPT) which was cited in the Keogh Report, which works as part of the Integrated Discharge Team providing a joint approach to assessment and care planning over seven days a week. We will build on these relationships and shared successes with the implementation of the BCF that provides unique challenges and opportunities, specifically in 2015/16 and 2016/17.

One of the main risks created by the BCF is the scale of the financial resources transferring to this fund which equate to £24m for Doncaster & £8m for Bassetlaw. From 2015/16, it is also a concern that 50% funding is performance related. It is therefore vital that we are actively engaged in discussions around performance criteria and achievability. The Integrated Care Board at Bassetlaw and Intermediate Care Board at Doncaster are monitoring the potential impact of the Better Care Fund.

To mitigate the above risks and to achieve the transformation requirements we have co-operated fully with our local authorities and commissioners in development of the BCF plans. In Doncaster this is through active participation as a member of the Health & Wellbeing Board.'

Rotherham, Doncaster and South Humber NHS Foundation Trust (RDASH)

'It is absolutely clear to the Trust, its partners and its stakeholders, that the health and social care needs of its local communities will only be met in the future through a 'whole system' approach to service delivery and engagement with these communities to propagate new, innovative and sustainable forms of support for its citizens. The Trust is engaged with the CCGs, local authorities, acute trusts, third sector consortia, NHS England representatives, Police, other service providers and key stakeholders in taking this work forward under the coordination of the respective Health and Wellbeing Boards.

The impact of the Better Care Fund is likely to be greater in Doncaster.
The Trust is however committed to supporting the Better Care Fund developments across all of its localities as part of an increasingly effective 'whole system' approach to meeting Health and Social Care needs.'

Appendix 2 - Doncaster and Bassetlaw NHS Foundation Trust Operational Plan 2014-2016 and Appendix 3 - Rotherham, Doncaster and South Humber 2014-2015 describe in more detail the commitment by both Trusts to work with local partners and to view BCF as a means to embrace, extend and strengthen the innovation already celebrated in Doncaster Health and Social Care Community.

The care provider sector was already engaged with the SMIP programme before the move towards the Better Care Fund. The BCF has given additional impetus to this relationship. A recent workshop with residential and care home providers focussed on the development of a Quality Counts Quality Matters Programme, to modernise and improve the quality within nursing and residential home settings. This dialogue will continue strategically through the Doncaster Residential and Nursing Home Forum and operationally through a new structured leadership programme with managers of all care providers in Doncaster. This change programme is also key work stream of the Community Nursing Review which seeks to modernize community based services and alternatives to hospital admission.

Domiciliary care providers have also been specifically engaged around the development of BCF as part of a new help to live at home model, which will see a significant shift in the

way we organise and deliver care around the person and outcomes. This will involve testing assumptions around external deliver of support planning and payment by results to keep people well and home for longer.

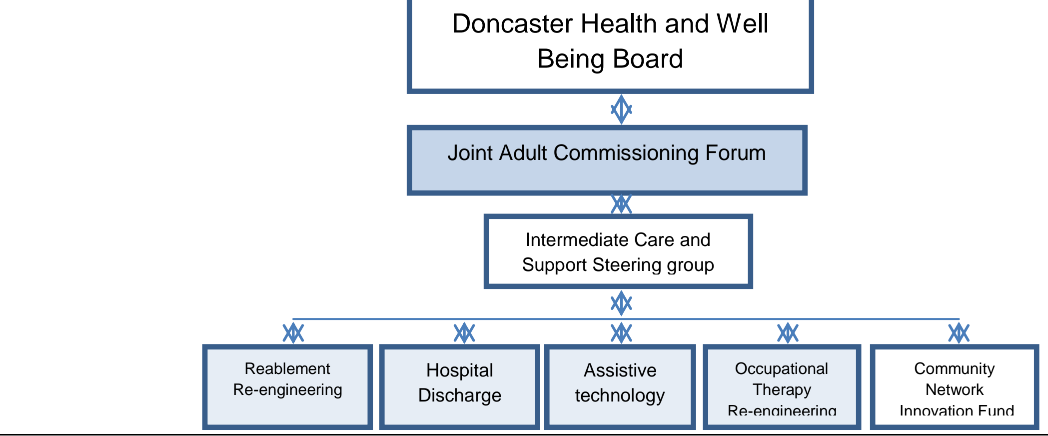
Initial discussions with Third Sector Providers about BCF ambitions via the Third sector Health and Social Care Forum have also brought new energy and vibrancy to existing relationships. In particular, the evaluation of the recently launched Community Funding Prospectus, a new approach to commissioning outcomes in Doncaster, will indicate how this approach can further drive and support the integration ambitions of the Better Care Fund beyond mainstream and statutory services. Early feedback suggests that a key strength of this approach in 2013/14 was the opportunity for collaboration and joint working between local agencies and this should be extended to BCF Plan priorities. Providers report that this approach reduces duplication and maximises the assets and skills of local communities. A new social prescribing collaboration between 2 local, third sector agencies, GPs and the DBHNHSFT is a prime example of the shift toward increasing integrated working beyond the statutory sector.

Further workshops to develop detailed 2 and 5 year plans around the 3 BCF themes will take place from April to September 2014.

Previous to the development of the Better Care Fund, providers in Doncaster have been integral to delivering the Supporting and Maintaining Independence Programme, the current theme of the Social Care and Health Development Programme (SCHDP) which is the name for existing pooled budget arrangements in Doncaster. The SCHDP will be incorporated into the pooled budget arrangements of the Better Care Fund.

The Social Care and Health Development Programme is a programme of service transformation using the current transfer of monies from Health to Social Care, via section 256 of the Health Care Act. Governed by a Joint Adult Commissioning Forum (JACF) and multi-stakeholder working groups, this approach has resulted in robust and innovative joint commissioner and provider planning and decision-making and has realised some significant improvements in key service areas in Doncaster. This approach to the Supporting and Maintaining Independence programme was held up as an exemplar of innovative practice by the LGA Peer review for Doncaster Adult services in January 2014.The SCHDP reports directly to the JACF and is governed by the Doncaster Health and Well Being Board.

Previous Social Care and Health Development Programme - Governance and Reporting Structure 2012-13.



Example working groups

All communities within Doncaster are integral to all of our planning and delivery processes. Central to the building strong and resilient communities element of the SCHDP programme, is the flagship Doncaster Community Innovation Fund. The Doncaster Community Innovation Fund is an outcomes based commissioning approach, infrastructure support and seed fund, that fosters innovation in “co-produced” solutions to health and well being at a person centred and asset based community prevention level. Panels of local providers, third sector and user group partners play a central and equal role in setting the annual prospectus of outcomes and in the decision-making process for funding awards. Year 2 of the programme will further promote provider partnership hubs at neighbourhood level referencing the North Devon and Cumbria value cases in shaping Help to Live at Home services.

The delivery of a partnership approach to short term intermediate care and reablement has been commissioned by the Joint Adult Commissioning Forum but designed and engineered through a “One Team Working” provider approach by DMBC and Rotherham and Doncaster and South Humber NHS Trust (RDaSH) provider services with in-reach to Doncaster Royal Infirmary (DRI). This successful approach has created clear integrated pathways for patient discharge and a through flow of patients back into the community.

Doncaster Council was an early adopter in the recognition process for Dementia Friendly Communities and signed up to the national Dementia Declaration. In 2013, Dementia was identified as a priority for both the Doncaster Health and Wellbeing Board and the Doncaster Clinical Commissioning Group (DCCG). The Council has played a key role in the development of the Local Dementia Action Alliance and is an active partner in the local Strategic Alliance working with health, third sector, and provider and carer representatives.

Key achievements include leading a successful bid which secured £1million from the Department of Health Dementia Friendly Environments National Pilot Programme. The funding will make a significant sustainable difference to people living with dementia in care settings including;

- The enhancement of an existing capital scheme for the development of dementia facilities at Doncaster Royal Infirmary, to King’s Fund environmental inpatient standards

- Enhancement of an existing capital approved scheme to equip inpatient community and mental health wards and the external environment (Windermere Lodge and Hawthorn Ward at St Catherine’s Hospital, Doncaster) to the highest dementia-friendly standards

- The creation of dementia friendly facilities to Extra Care housing provision with dementia. The environment will be purpose built to ensure that it is dementia friendly using The King’s Fund’s ‘Developing Supportive Design for People with Dementia.

The Supporting and Maintaining Independence Programme, the delivery of community based co-produced initiatives, the short term reablement and intermediate care offer and the innovative partnership approach to Dementia, has both providers and users at the centre and front of developing key outcome priorities that deliver a resilient approach to

future sustainable integration.

The whole approach (and future schemes as part of the Better Care Fund) is being academically evaluated through a 2 year partnership with Sheffield Hallam University.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it.

The Better Care Plan has been developed using a range of existing patient, user and public engagement intelligence and feedback as part of on-going extensive user and citizen engagement activity across health and social care in Doncaster. Key to the success of the Doncaster Better Care Fund will be the on-going conversations with the people of Doncaster about the priorities of our local communities.

A full and meaningful engagement programme with a range of patient and service user groups, for example Health Watch, the over 50's parliament, Doncaster CVS, New Horizons (Doncaster Councils infrastructure partners), GP and patient forums have already shaped the headline Better Care Plan themes and in particular the approach to building the strong and inclusive communities strand. Each of these key representative groups are part of the Doncaster Health and Well Being Board arrangements and is fully involved in the development of and awards made from the Doncaster Innovation Fund. Doncaster Council community based Well-Being Officers are also a significant resource in the continuous loop back from communities to key decision-making and change structures and were highlighted as an example of good practice in the recent LGA review of Doncaster Council Adult and Community services.

We have also agreed that the BCF public patient and user engagement plan will now form a key work stream of the Stronger Communities planning structure, ensuring that BCF is part of mainstream engagement rather than a bolt on activity.

In Doncaster we have an established Safer Stronger Partnership Board as one of the 4 Boards within the Local Strategic Partnership *Team Doncaster.* The Safer Stronger Partnership Board is supported by a Stronger Communities Theme Group, which in turn has 3 working groups aligned to;

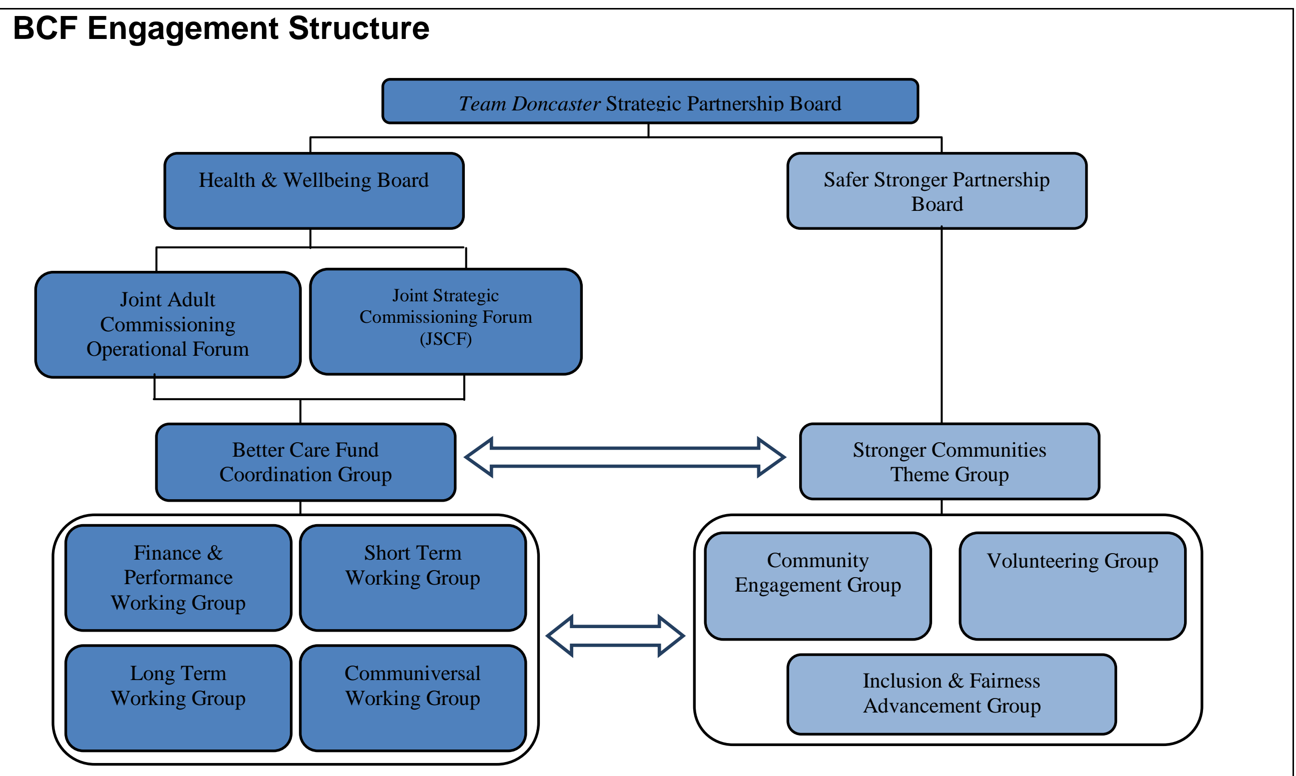
a) Community Engagement

b) Volunteering

c) Inclusion / Fairness.

Mapped below to our Better Care Fund governance structure, this provides us with a ready-made, partnership-working, embedded structure to take forward Better Care Fund engagement as a cohesive programme of work rather than a completely separate initiative.

BCF Engagement Structure



Appendix 4 provides more detail on how we have strengthened our position on stakeholder and user involvement and our plans going forward, since the first cut of the Doncaster BCF Plan.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Appendix	Document/Information Title	Synopsis and Links
1.	Social Care and Health Development plan 2013/14 (Supporting and Maintaining Independence)	The current headline themes of the 2013/16 programme of change and transformation activity that is funded via the transfer of Section 256 monies and managed via a Joint Health, Social Care, Public Health and Communities Board that reports to the Health and Well Being Board. The programme has 9 Key themes which already address some of the key areas of change that will form a part of the Better Care Fund plan going forward.
2.	Doncaster Community Funding Prospectus	The 2013 outcomes based community commissioning prospectus, which was developed to foster innovation in solutions from local third sector, private and community enterprises.
3.	The Road to Integration	A road map towards a single view of integration and connected care intentions across the Doncaster Health, Social and Community Care landscape.
4.	DMBC Adults and Communities Prevention Strategy	Outlines our strategic intentions for the next three years towards a prevention offer for communities that continue to ensure statutory services are flexible, responsive and timely keeping people independent for longer.
5.	Draft - DMBC Adults and Communities Modernisation Strategy	Outlines how Doncaster Council with partners is going to reconfigure its approach to delivering person centred support for our citizens.
6.	DMBC Adults and Communities Commissioning Strategy	Outlines our intentions to build a road from a traditional procurement approach to co-produced commissioning activities
7.	Dementia Delivery Plan for DCCG	Doncaster NHSCCG Dementia Plan on a page.
8.	Outcomes Based Accountability (OBA) Template 2012	Doncaster Outcome based accountability template for Dementia.

9.	Dementia Friendly Communities Action plan	A 6 month action plan for delivering the aspirations of the Dementia Friendly Communities plan
10.	DMBC DOH Award submission	Copy of successful DMBC, DOH award for Improving dementia friendly Environments.
11.	Doncaster CCG 5 year strategy	An outline 5 year vision for commissioned health services in Doncaster

***Additional Appendices to support second cut submission**

	Document/Information Title	Synopsis and Links
1.	Doncaster Better Care Fund plan 2014-16.	Provides the proposed key work stream areas within each of the 3 plan themes, with start dates where this is agreed.
2.	Doncaster and Bassetlaw NHS Foundation Trust Operational Plan 2014-2016	Sets out the ambitions of the Trust over the next 2 years with clear reference to the impact and opportunities presented by the BCF.
3.	Rotherham, Doncaster and South Humber Draft Operational Plan 2014-2015.	
4.	Better Care Fund Communications & Engagement Strategy	
5.	An Example of the Doncaster Home From Hospital Performance Plan	Demonstrates an example of how we will measure activity across a number of domains for all schemes with BCF investment
6.	BCF Academic Evaluation Plan	Details the work streams contained within the academic partnership plan.

2) VISION AND SCHEMES

2a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our vision is to create a co-produced, sustainable system of integrated care and support for people in Doncaster that;

- **Builds strong and inclusive communities -** recognising that this is the key to prevention and maintaining health and wellbeing.
- **Is coordinated around individuals -** targeted to specific need and recognising that individuals are their own best integrators of care.
- **Improves outcomes -** reducing premature mortality and increasing health and wellbeing.
- **Improves the experience of care -** with the right services when needed available at the right time
- **Recognises** the crucial role that Carers and informal networks play in maintaining independent living
- **Maximises independence by providing -** more support at home, in the community and tailored to need, focused on outcomes.
- **Provides joined up and proactive case management -** to ensure we avoid unnecessary admissions to hospital and care homes and rapidly regain independence after an episode of illness.
- **Ensures quality counts and quality matters -** robust systems for continuous review that builds on assets as well as deficits.

The changes in pattern and configuration of services will be based upon 4 core principles;

- **People are themselves the best integrators of care -** we will help people to direct their care and support and ensure it is tailored to suit individual needs by being available at the right time and in the right place.
- **Services and support as close to home as possible -** we will ensure that as many services as possible are developed in the community with a preventative and co-production approach.
- **Services will be integrated -** where possible and connected as a minimum.

- **Systems and processes -** will enable integration and connect services.

  We will improve patient and service user experience through;

- **Making it Real Together -** A whole system adoption of Making it Real markers of progress. Ensuring that we begin with the end in mind and use Making it Real as a basis for developing, delivering and measuring person centred approaches.

  - *Support planning tools, review systems and performance monitoring activity will be based on Making it Real programme markers that are agreed with patients and users in the development of fund activity.*

- **Commissioning for Outcomes Together -** Establishing an effective and consistent model for joint/integrated outcome based commissioning that is underpinned by co-production.

  - *An integrated commissioning register will demonstrate reductions in duplication and streamlining of investment in the health and social care system.*

- **Developing the Workforce Together -** System wide adoption and Implementation of an integrated workforce development programme designed to embed person centred practice across the local health and social care system

  - *Performance monitoring and evaluation will demonstrate gains in workforce skills and the application of person centred approaches.*

- **Building Processes Together -** Assuring progress by learning from experience and evidence to identify and find solutions to process issues that prevent effective commissioning and co-ordinated delivery.

  - *Integrated performance and evaluation reporting is applied at operational and strategic planning levels.*

The services and support we will have developed we expect, when tested, to meet the following values;

- Services that wrap around the individual and are at or are as close to home as possible
- Maximise individual and community assets
- Reduce dependency and increase personal responsibility
- Increase patient/citizen control and choice
- Adopt a reablement and preventative approach
- Consider the wider determinates of health and social well being
- Are continuously reviewed for quality and need.

Our performance and evaluation plans will ensure that all themes and schemes are tested against these ambition statements as well as the metrics required for BCF performance. A sample of this performance management approach is attached at Appendix 5.

Our programme work plan (appendix 1) provides more detail around the themes and schemes that aim to deliver the changes, to realise our ambitions and the BCF targets within the principles outlined. Our responsibilities under The Care Bill are also now included in these plans.

Mental Health

Doncaster CCG in partnership with DMBC are currently reviewing the position and ambitions for mental health services and how we plan to respond locally to the National Mental Health Concordat and local delivery of community based services.

Mental health touches everyone and it is the responsibility of every organisation to work together to ensure high quality and effective services for people who experience episodes of poor mental health. The Mental Health Alliance (partnership board) brings together community based providers, commissioners and user led organisations to ensure appropriate, effective connected services and that mental health is a cross cutting theme across all service areas. Similarly partnership performance is monitored by the health and wellbeing board and this positions mental health in Doncaster as a key local priority area. This focus on partnership leads to a number of innovative initiatives including a housing and tenancy support scheme for people with complex mental health conditions.

Over the next 2 years the alliance will focus on new models of service delivery based on;

- **Universal and Prevention services** - access to support before crisis point and a move to models of peer support.
- **Short term treatment services** - urgent and emergency access to crisis care
- **Long term reablement services that feedback into universal services** - recovery and staying well and preventing future crises

We will agree, locally, how these different services can best work together and it establish key principles of good practice that local services and partnerships should use to raise standards and strengthen working arrangements.

Our local commissioning priorities on the development of local specialist and mental health Crisis pathways are also reflected in the RDASH Operational plan for 2014-16 and mental health will be a priority within the Long Term working group. A draft Project Initiation Document, **Doncaster CCG & Rotherham, Doncaster & South Humber NHS Trust - Mental Health Change Programme** is also at consultation stage.

The Care Bill

We are also able to further describe our position for implementing the requirements of The Care Bill and this is reflected in additional work streams that have been included in Doncaster's BCF work plan. The responsibilities for delivering the Care Bill will be incorporated into Better Care Fund governance arrangements.

The recent Care Bill self-assessment process shows that Doncaster is in a strong place

in terms of commissioning arrangements and is likely to meet the requirements across most other domains by the 2016 target date. For example we expect to see significant changes in our system by reconfiguring delivery of assessment and care. We intend to commission a new community brokerage service that will provide a support planning function for those in receipt of community based services meaning that specialist resources can focus more on assessment. There will also be a delivery framework for information and advice that will support our Communiversal approach. This is being underpinned by a culture change programme including staff awareness of their legal duties once the bill is enacted.

In the next 3 months the 3 BCF strategic working groups will be developing benefits realisation plans for each of the themes and major schemes within the programme to ensure we have the best chance of focusing effort where most gain can be realised.

3a) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Our aim is to transform the culture of care and support in Doncaster to be more person centred, individualised, connected as a minimum, integrated where possible, easy to navigate and focused on outcomes. We aim to focus equally on building strong and resilient communities that are supported to take an equitable share of health and social care responsibility and recognise that communities will be as important as statutory partners in delivering an integrated system. People must be at the centre of a co-produced offer.

The objectives in Doncaster have been set by Doncaster citizens. The system we create will be able to deliver and be evaluated against the statements which have been developed by Doncaster citizens as part of our prevention, modernisation, commissioning and Health and Well Being Board strategy development. In Doncaster these are referred to as 'I' statements as they have been created by the citizens for the citizens and put each individual at the centre of our approach to Health and Social Care in Doncaster.

- *I'm able to enjoy life*
- *I feel part of a community and want to give something back*
- *I know what I can do to keep myself healthy*
- *I know how to help myself and who else can help me*
- *I am supported to maintain my independence for as long as possible*
- *I understand my health so I can make good decisions*
- *I am in control of my care and support*
- *I get the treatment and care which are best for me and my life*
- *I am treated with dignity and respect*
- *I am happy with the quality of my care and support*
- *Those around me are supported well*
- *I want to die with dignity and respect.*

The Doncaster Better Care Fund will achieve, as a minimum, a significant impact on the following outcomes;

- Admissions to residential and nursing care
- Proportion of older people (65 and older) who were still at home 91 days after discharge from hospital into reablement/rehabilitation
- Delayed transfers of care
- Emergency admissions and unplanned care
- Patient/user service/experience
- Telecare installations

In addition to these, significant contributions will be made to the following Joint Adult Social Care, Health and Public Health outcomes;

- Proportion of people who are offered reablement/rehabilitation
- Effectiveness of reablement
- Social Isolation
- Dementia diagnosis and reducing the stigma associated with dementia diagnosis.
- Quality of life

Underpinning these specific ambitions we aim to create a joint approach to care planning and assessment, an increase in integrated service provision and improved data sharing between Health and Social Care.

Our 2 year partnership with Sheffield Hallam University will provide academic rigour to how we demonstrate and attribute gain across these measures, in particular around quality of life. Academic support for the development of a new universal outcome based support planning and quality measurement system, will allow us to test the impact wider than traditional health gain measures and in particular to form evidence based upon what works in supporting and maintaining independence and wellbeing. The aims and objectives of the academic partnership are as follows;

- Identify the impacts of Better Care Fund programme activity
- Measure economic and social return on investment
- Provide evidence to support decision making and commissioning activity
- Build research and evaluation capacity, skills and knowledge.

Appendix 6 describes in more detail the 4 work streams outlined below;

Strategic capacity building - Doncaster has formally agreed to work as a case study with CLHARC Yorkshire and Humber. Director support for this programme means that Doncaster partners will work toward being a proactive research and evidence based practice partnership.

An **operational capacity building plan** will ensure that the integrated workforce develop the knowledge and skills to ensure that research and evaluation will become core practice at all levels of the organisations.

2 in-depth evaluations will focus on the effectiveness of our current intermediate care

system from a client perspective and this will be enhanced by implementing a new **Quality of Life tool** across core reablement, OT and wellbeing services and all new services with BCF Investment. The aim of the quality of life tool is to bring a consistent approach to how we measure the social impact of activity and interventions, what balance of activity works best in in prevention and maintaining independence and how this should inform future commissioning decisions.

The Social Return on Investment approach aims to take us to a place where activity in Doncaster can be evaluated both on an economic and social value basis.

Academic Evaluation Structure Overview

A more detailed plan showing the relationship between work streams is attached at appendix 6.

4a) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

There are a number of building blocks already in the Doncaster system that can be built on to facilitate true system integration and will be developed further at the second stage of planning of the Better Care Fund in Doncaster.

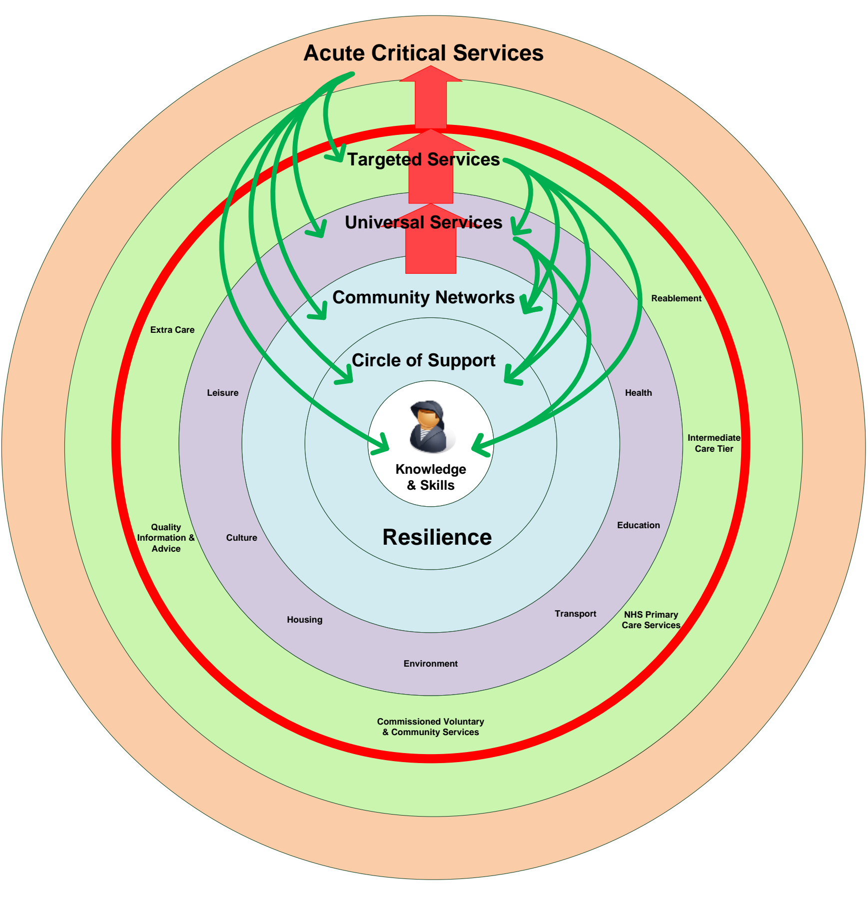
The corner stone of all of our plans is person centred co-ordinated care and support, which focuses on assets as well as needs that if kept at the heart of all our activity, grounds us in a level of simplicity focused on the person. Capturing and capitalising on this simplicity and realism forms the basis of our ambition for patients, service users, carers, communities and the future of care and support in Doncaster.

Asset Based Health and Social Care: A Whole System Approach

Asset based health and social care seeks to recognise patients and service users as citizens first. As citizens they have rights and responsibilities and also the best enablers

and integrators of their own care and support. Asset based health and social care starts with an assumption that all citizens wish to live independent lives, and that most do successfully without any state intervention, drawing on personal knowledge and skills, natural circles of support and community resources available to them in the way that suits them.
The role of Health and Social Care partners will be to enable those who need additional support to achieve independence to be able to access this in the way that best meets their needs and is tailored to their own particular circumstances. They will achieve this by drawing on universal, targeted and acute critical services.

To be successful in this approach the Health and Social Care system will need to change from being a deficit to asset based, changing the conversation from what people can't do addressed by limited menus of service provision, to what people can do, with support designed by themselves with the help of Health and Social Care professionals/advocates.



Red Arrows = Increasing Need

Green Arrows = Decreasing Need

Community Networks

Universal Services

Targeted Services

Acute Services

The case study below gives an example of how the future will look for one of our local citizens;

Mavis is 82 and lives in Conisborough. She has a low income and lives alone in a Housing Association house which she has lived in for 50 years. She is recently widowed. She misses her husband, who was her carer and organised her medicines. Her family all now live away and the friends she used to talk too have either died or moved into Care Homes. Mavis wants to stay in the home that she has lived in for most of her adult life, where she has memories of her family and some good neighbours, but she is lonely and often feels depressed.

Mavis has multiple long term conditions including Diabetes, Arthritis, COPD and early signs of possible Dementia. However, she does have capacity and is managing well at the moment.

She does not receive homecare services but she has had some minor adaptations made to her home such as grab rails, as she often wobbles on her feet. She can cook, but has to rely on her neighbours to do her shopping. She misses shopping as much for the lunch she used to have at the supermarket, as she does for the independence and choice it provided her every week.

Since her husband died, she makes frequent 999 calls, because she is not sure what else to do when she is worried and unwell. She makes several A&E visits each month, each time staying at least overnight for observation.

Here are 3 scenarios where the new integrated system will be able to support Mavis to remain independent and live at home;

Short Term support
Intermediate Care

Following a call to 999 Mavis is taken to A&E. Instead of being admitted to hospital unnecessarily she is seen by one of the Integrated Transfer Team who are co-located at the hospital. They suggest that Mavis would benefit from a single outcome based assessment to look at her Health and Social Care needs, but that this would best be done at home. They refer her to the Integrated Reablement Team and the trusted assessor meets Mavis at home within a two hour period.

In partnership with Mavis an asset based support plan is developed which focuses primarily on what Mavis can do for herself. The installation of Telecare equipment, and a falls assessment is an integral part of her assessment as this will further support Mavis to feel safe particularly during this initial period. Mavis receives 2 visits each day for 3 weeks from the Reablement Team, throughout this period the support workers enable Mavis to maximise her independence and confidence through an Occupational Therapy plan which includes activities of daily living.

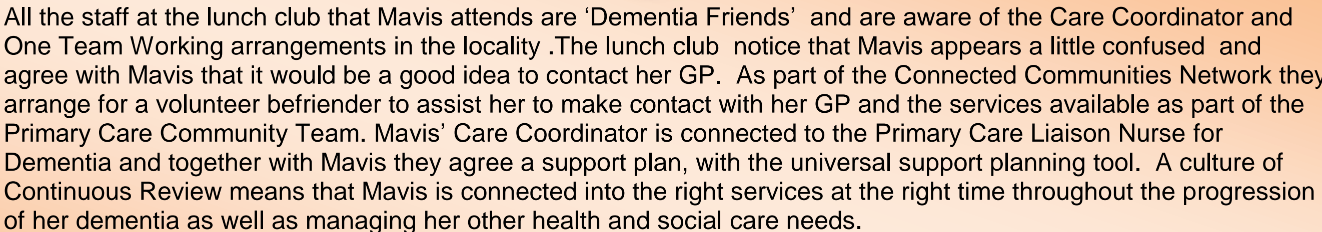
Mavis' progress is monitored through a reablement Case Manager led Multi-Disciplinary Team which responds to any fluctuation in need. As Mavis regains her independence the Case Manager will start to assist her to connect with her local community by facilitating a referral to the Well Being services.

'Communiversal' services
Community Support

Following a call to the local authority by her neighbour to say Mavis was struggling to put her bin out, Mavis agreed to and received a call from the Community Well Being Officer. The Well Being Officer visits Mavis and carries out a support planning assessment which looks at Mavis's assets and needs. As a result of this assessment they make a referral regarding her benefits and connect her with the local chair based exercise group, which helps keep her mobile and reduces her risk of falling. The Well Being Officer also talk to Mavis' neighbours to see if there is any support they might need as informal carers for Mavis.

Mavis is also connected with the local Community Dementia café, who are able to support her as her condition progresses. This group is also connected into the Winter Warm scheme and when the weather changes, Mavis receives a winter warm pack and some help in keeping her house warm.

Mavis now attends A&E less often and is in regular contact Care Coordinator from the Primary Care Community Team. The Care Coordinator is a member of the MDT who is best placed to holistically coordinate Mavis' support. This assists in keeping grip of and accountability for Mavis' package of care and is a big relief to Mavis who previously had to contact lots of different people.



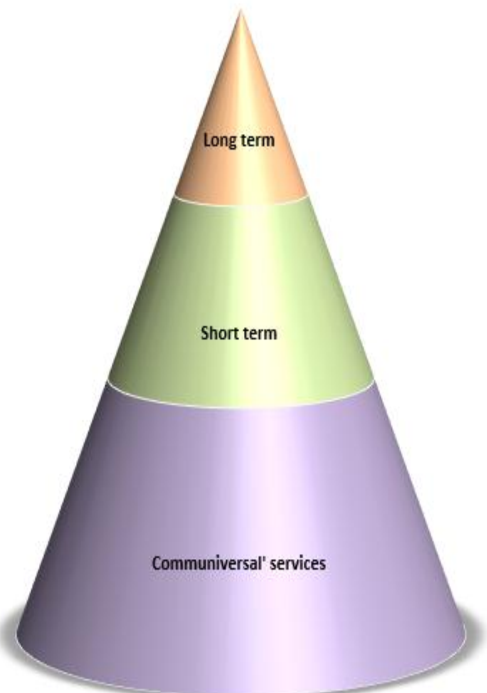
All the staff at the lunch club that Mavis attends are 'Dementia Friends' and are aware of the Care Coordinator and One Team Working arrangements in the locality .The lunch club notice that Mavis appears a little confused and agree with Mavis that it would be a good idea to contact her GP. As part of the Connected Communities Network they arrange for a volunteer befriender to assist her to make contact with her GP and the services available as part of the Primary Care Community Team. Mavis' Care Coordinator is connected to the Primary Care Liaison Nurse for Dementia and together with Mavis they agree a support plan, with the universal support planning tool. A culture of Continuous Review means that Mavis is connected into the right services at the right time throughout the progression of her dementia as well as managing her other health and social care needs.

The universal support tool and single assessment approach allows her to discuss plans for the future and she has expressed she would like at the right time to move to the Dementia Friendly Extra Care Facility in the locality. Mavis also discusses with her care coordinator how she would like to manage the end stages of her life and together they create an Advanced Wishes and Living Will.

Long Term Services Dementia and Community Care

In order to 'Make it Real' for Mavis It is proposed that Better Care Fund Plan will focus on three broad headline themes;

- **Community and Universal services** – Information, advice, community support and self-management
- **Short term services** – Intermediate Care Services and support
- **Longer Term services** – Dementia and Community Care



These themes both reflect the Adult Commissioning Strategy priorities within DMBC Adult Commissioning and the NHS, DCCG, 5 year strategy and 2 year operational plans. The focus of the plan shifts preventative, community and home based services into the forefront of the Better Care Fund plan and ensures that supporting and maintaining independence is central to and permeates all provision throughout the integrated services model.

As an outcome of a recent Doncaster Health and Well Being Workshop, we have developed further our joint understanding and description of the focus of the 3 theme areas. We have set out below the work areas which we will build on from existing development plans and new areas of Joint working which BCF has prompted as an opportunity. The plan also includes our responsibilities within The Care Bill that should be delivered via the BCF pooled budget and also those areas receiving additional Care Bill funding. Combining Care Bill planning within the BCF governance structure ensures that joint planning permeates all our future activity. The schemes below are detailed within the BCF programme work plan. (Appendix 1)

- **Community and Universal services**

.An integrated approach to community capacity building and effective universal services based on the five elements of the Think Local act personal framework, mutual support,

inclusive community organisations, connecting people to communities and services, reshaped inclusive targeted and universal services and building and reshaping communities.

This theme will include as a minimum the following work areas;

- Public Health- evidenced based programmes that impact on the wider determinants of wellbeing.
- H&SCB National information campaign
- Community Innovation and developing the market of Community providers.
- Information, advice and advocacy services
- Integrated Social prescribing scheme.
- Veterans
- Carers – timely and appropriate help that recognise the vital role carers play
- Peer support services – including Mental health
- Wellbeing services
- Falls Network and Pathway
- Next phase development of One Team Working, Primary Community Social Care and Health teams and Accountable Lead Professional.
- Community equipment and adaptations.

➢ **Short term services**

Interventions that preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or inappropriate admission to hospital or statutory care. Care is person-centred, focused on rehabilitation, outcomes that maximize holistic wellbeing and which utilizes community and peer resources as well as statutory services

This theme will include as a minimum the following work areas;

- Intermediate Care Needs assessment
- Transfer and assessment environments
- Early supported discharge and Post discharge Community support services
- Reablement and rehabilitation services
- Home from Hospital services
- Integrated Crisis response
- End of Life

➢ **Longer Term services**

The long term, on-going, continual delivery of care, support or treatment at home, in the community and within institutional settings for people in Doncaster Borough

- Housing Options Offer
- Assistive Technology
- Dementia Friendly Communities
- Help to Live at Home
- Shared Lives
- Quality Counts Quality Matters (Part CB)
- PDSI

- Connected Care
- Disabled facilities programme
- Personalisation
- Care First development
- Assessment and Eligibility (CB)
- Capacity (BC)
- Deferred payments (CB)
- Personalisation (CB)
- Safeguarding (CB)
- 7 Day working programme

A number of cross cutting themes will be managed by a dedicated programme office including;

Better Care Systems and Programme Management

In addition investment into support systems to aid integration and connected care will include the following;

- **Better Care Fund Programme Governance and programme and project management –** Joint resource to support the implementation of integrated commissioning of health and social care

- **Integrated performance, monitoring and evaluation -** Ensuring data sharing and interpretation is core to service and systems planning and commissioning.

- **Implement routine patient and user evaluation and surveying -** To enable the capture and tracking of the experience of care including QOL.

- **Integrate NHS and social care systems -** Around the NHS Number to ensure frontline professionals, and ultimately all patients and service users, have access to all of the records and information they need

- **Workforce Development -** Investing in the skills and talents required for a modernised workforce across the system of planning, performance and delivery.

5a) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

A key aim of the partnership is to avoid hospital admissions and provide community based acute hospital avoidance services and comprehensive integrated rehabilitation and reablement services.

The impact on the acute sector needs to be modelled and agreed in more detail and in

partnership with the local acute provider in detail, however, it is expected that there will be a focus on providing efficient high quality planned care services, a responsive A&E, acute emergency services and the development of capacity and capability to manage older people who are frail and have an increasingly complex clinical need.

It is expected that during the next 5 years, there will be a significant reduction in non-elective activity and a significant improvement in planned care productivity. The transition to a community focussed patient offer requires some parallel running of services. This will be achieved using non recurrent resources as the transition takes place.

Following early discussions, our acute sector partner has indicated both the challenges and opportunities of the Better Care Fund and these are outlined in more detail in appendix 2.

'We recognise that DBH will need to adapt and transform to meet the changing needs of the population, further accommodate the integration of care and the increasing centralisation of specialised services. This two year period is also unique in terms of the "affordability challenge" including the introduction of the Better Care Fund (BCF). The implementation of the BCF will create challenges and opportunities. The scale of the financial resources transferring to this fund equate to £24m for Doncaster & £8m for Bassetlaw. We have the opportunity to continue to work with our partners to provide the right care in the right place for our populations. We have already commenced this work and have nationally recognised integrated discharge services and are actively engaged in the BCF planning discussions.

Set against this funding backdrop we have additional challenges that include implementation of seven day working to improve quality and the recruitment of staff to deliver evidence based staffing levels in line with the Safer Nursing Care Tool (SNCT). We need to ensure that this investment, alongside effective utilisation of other resources, provides opportunities in terms of patient experience, reduced length of stay and implementation of BCF schemes so that we can reduce our inpatient footprint whilst continuing to meet national compliance targets such as Referral to Treatment (RTT) and the 4 hour access target.
Working with key stakeholders and partners as part of the local health economy to address this challenge and others is fundamental to providing appropriate, high quality and cost effective services.'

Any wider implications on the acute sector, across our neighbouring health and social care economies, will be managed through the 'Working Together' programme, where the five local CCGs meet, horizon scan and plan with the local NHS Foundation Trusts.

All key providers will be involved in on-going joint development and planning activity through the BCF governance structure.

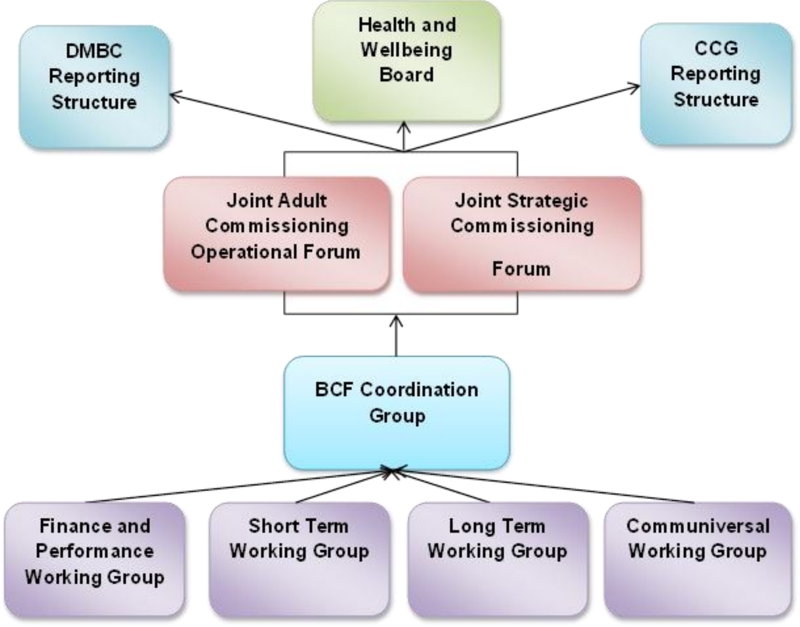
6a) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Building on the foundations of the Joint Adult Commissioning Forum arrangements, it is proposed that the JACF will continue to manage the Better Care Fund, overseen by the Health and Well Being Board to ensure corporate support and guidance for the strategic ambitions of the programme.

The new governance structure described below is in development and over the next 2 months there will be a transition to these new arrangements. This will include quarterly Joint Chief Executive Governance and Planning meetings and quarterly reporting to the Health and Well Being Board.

Better Care Fund Governance 2014/15



The BCF programme will operate under the Health and Wellbeing Board and will use a number of delivery mechanisms;

- Programme Management
- Multiple stakeholder steering group
- Service user/patient and carer expert reference groups
- Staff reference groups
- Innovation and research panel/support structures
- Reporting arrangements
- Evaluation covering domains for patients, staff, organisational, partnership and financial benefits
- Dissemination of findings

How we operate as an integrated commissioning, planning and delivery system will be governed by the following key principles;

Principle 1 - The allocation of the Better Care Fund monies will take place within the wider framework of the adult social and health care transformation and modernisation processes. This principle recognises that the focus is on system wide integration, getting **a single view of the use of resource** and that this has greater value in both cash and service delivery terms than of using monies in isolation

Principle 2 - Patient and user involvement and working towards a co-production approach, will be an integral part of developing and delivering the new offer for services, recognising that increasing community capacity, social capital and self-reliance requires and investment in and engagement with local people

Principle 3 - The use of monies should be focussed towards a **new offer** recognising that sustaining current systems is not possible within the resource settlement across Health and Social Care. This principle recognises that **priority for funding allocation** should be on **developing capacity** within the system and **targeted interventions** to manage care and health demands within **new resource limits**. Supporting existing business pressures will be a valid use of monies if new ways of working and sustainability are an integral part of the case for change

Principle 4 - The development of an integrated intelligence system will be supported by a culture of performance and evaluation, ensuring that the services and system we develop is based on the best available evidence and that continuous improvement is embedded as a principle and value throughout the workforce

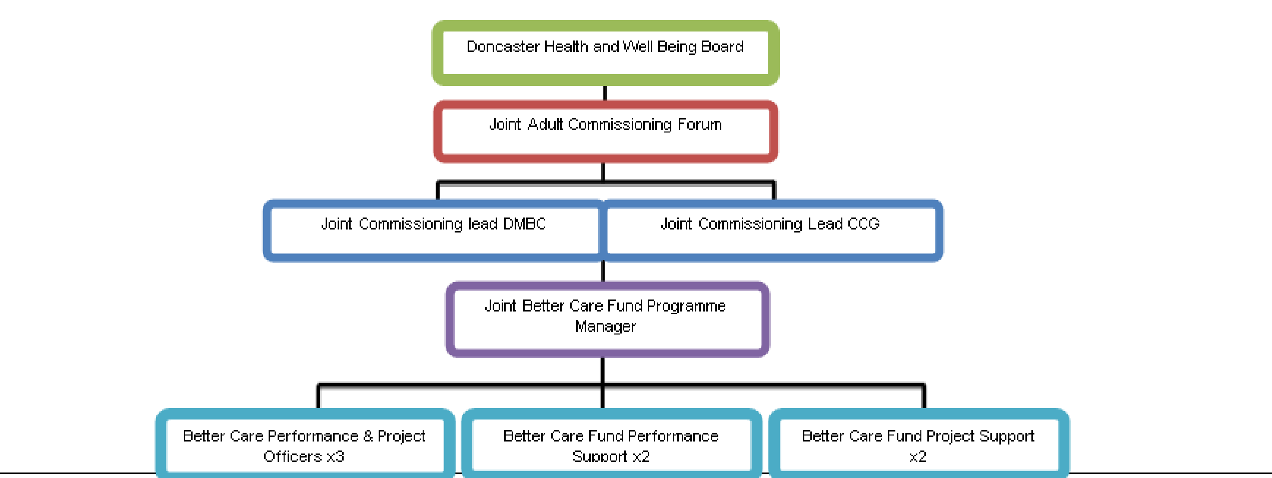
Principle 5 - With the emphasis on maintaining the safety of patients, service users and carers, and avoidance of discrimination, there is a commitment to **joint responsibility for development and change.** This principle recognises that any changes and new ways of working impact across both Health and Social Care systems

Principle 6 - The Social Care and Health Community will work together to ensure and establish a system of **transparency, participation and collaboration**. Openness will strengthen our decision making and promote efficiency and effectiveness in programme and service development

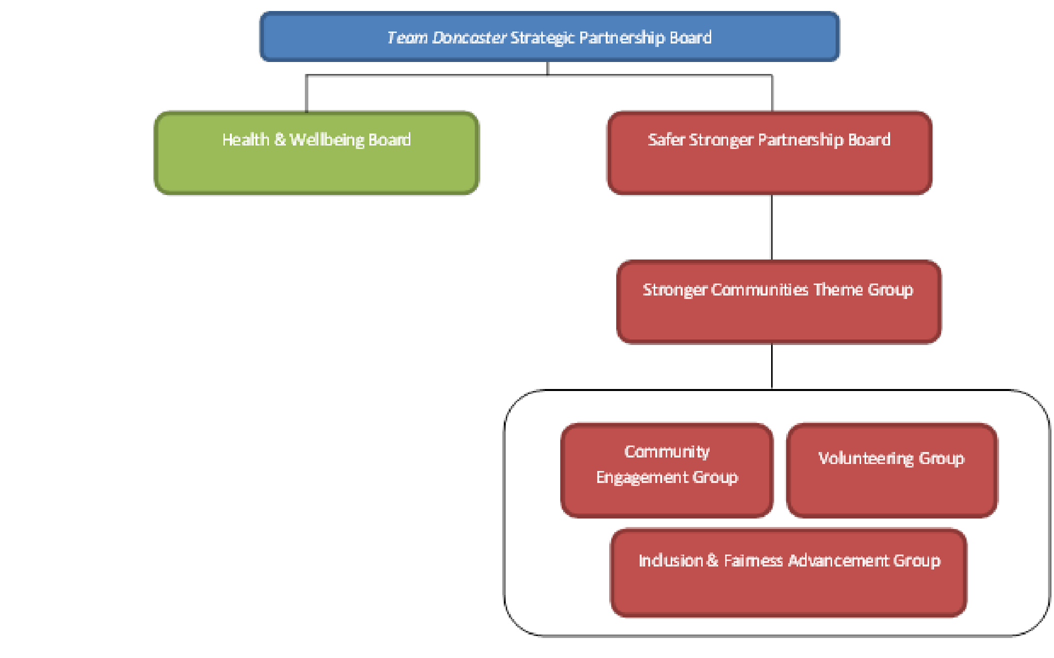
Principle 7 - In accordance **with local compact agreements** the voluntary sector will have an opportunity to influence the Social Care and Health Development Programme. This principle recognises that to achieve a transformation in services which reduces dependency on statutory services and **increases independence,** third sector agencies have a significant role to play.

In addition to the current governance and planning structure a dedicated programme team ensures robust and effective programme and project management and these arrangements will be extended to support the management of the Better Care Fund. This programme management approach ensures multiagency system wide planning, whole system performance monitoring and operational implementation that manage interdependencies across the health and social care system.

Better Care Fund Programme Team - Management and Reporting Structure



The governance structure will be further strengthened by the now formal links with the safer stronger partnership board which will ensure that a wide stakeholder group is formally engaged through the development and delivery process and that outcomes and progress on BCF becomes embedded into wider governance function.



3) NATIONAL CONDITIONS

a) **Protecting social care services-** Please outline your agreed local definition of protecting adult social care services.

In Doncaster our aim is to continue to meet the level of need of our citizens but to develop new and innovative ways of meeting that need through integrated systems, better care planning and co-production. Our ambition is to maintain service delivery, meeting statutory need where required, but our focus will be on new ways of joined up provision that will ensure individuals remain healthy and well and as independent for a long as possible.

Please explain how local social care services will be protected within your plans.

The whole of our Better Care Plan is about protecting and enhancing social care as our focus is on protecting and improving whole life experience and tackling the wider causes of ill health and not just on the delivery of statutory services. Central to this approach will be a shift to co-produced services and community solutions.

Within the 2014-16 work plan there is a clear focus on new and innovative and connected schemes to support people at home rather than maintenance of the existing system or dis-investment in social care. This demonstrates our continued commitment, which began with SMIP 2 years ago, to investing and modernising social care across the partnership.

b) 7 day services to support discharge
Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

We are adopting a system wide approach to rolling out 7 day working across Health and Social Care Teams, with the focus on integration. Already since the first cut plan we have agreed to maintain extended hours for integrated discharge from hospital and we will be reviewing the impact of current arrangements in April when the first full data set and performance report is due. Early data reports indicate that an increase in discharge activity will be significant since the introduction of the pilot scheme.

In Doncaster we have prioritised the teams focussing on discharge from our acute hospital services, bringing together nursing and therapy staff from there, with the community Foundation Trust and associated social care teams, aligning services to form an Integrated Discharge Team which incorporates RAPT, STEP, CICT, Assessment Beds and Care Homes.

The next phases of work will assess the ability of those services and teams to cope with peaks and troughs in demand and whether they have the appropriate skill mix to deliver a 7 day service. As a result of this work we are also assessing the availability of other services on a 7 day basis including community equipment services, medical and pharmaceutical services, hospital transport and other community based services. We are also identifying areas on patient pathways where discharges can be improved with better planning to ensure best use of resources through a 7 day service, but recognising not all are needed 24 hours, 7 days per week.

The Joint Adult Commissioning Forum has agreed that this will be an early priority in the next stage plan and will be a cross cutting theme for all 3 working groups, to ensure that demand for extended working is met across the whole of the health and social care system.

c) Data sharing
Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

Where possible the NHS Number is used to match services users/patients across health and social care services. The Social Care Case Management System is partially populated with NHS Numbers and plans are in place to complete the job. The NHS number is already routinely used within health services in Doncaster.

There is a commitment across the Health and Social Care system in Doncaster that once NHS numbers are fully populated, data will be appropriately shared across services for the purposes of service user/patient care, in line with IG requirements. It is also expected that aggregate data, built from anonymised patient level pathway data, will be used for planning purposes in the medium term future.

In addition, NHS Doncaster CCG has been accredited by the Health & Social Care Information Centre as an Accredited Safe Haven (ASH), and an assessed pre-requisite of this accreditation was achievement of Level 2 in the NHS Information Governance Toolkit (IGT). The use of the NHS Number in all healthcare settings is a requirement of Level 2 in the Information Governance Toolkit. Information Sharing Agreements are in place between NHS Doncaster CCG and relevant organisations with which we share data.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

An automated lookup service is available from the Social Care Case Management System provider at no cost. This requires NHS data to be provided for matching purposes. It is the intention of DMBC to include universal NHS number recording as part of new business processes by March 2015 which will be integral to the care management system - Carefirst.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Commissioners and providers in Doncaster including the local authority are committed to adopting systems that are based upon Open APIs and Open Standards.
DMBC and RDaSH ICT Departments are working together to put local secure arrangements in place to allow access to systems from each other’s networks without the need for complicated additional security arrangements.

The specification of the new Adult Social Care Case Management System currently being implemented allows sharing of information between third party systems, subject to the availability of APIs and a detailed specification of data sharing requirements.

Furthermore, NHS Doncaster CCG chairs a Doncaster wide Information Management & Technology (IM&T) Forum which is exploring a range of data sharing opportunities through the joined-up solutions across the Acute Trust, the Mental Health & Community Trust, the CCG and the Council. Consideration is being given to a shared Public Sector Network Solution and the Medical Inter-operability Gateway (MIG).

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practise and in particular requirements set out in Caldicott 2.

Doncaster has an established Information Governance Framework which covers both NHS and Local Government requirements. It facilitates the sharing of data across Health and Social Care partners and has supported the development of a Joint Performance Team and system reporting to the Health and Well Being board that will support Better Care Fund activity.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

All GP Practices in Doncaster are currently using the Risk Stratification system to identify which patients, from all those patients registered with the practice, have a high risk of emergency admission for a chronic condition. The particular population focussed on is all patients with one or more long term conditions. Percentages risk is calculated for each patient and is the % chance of an emergency chronic admission. Risk is scored as follows:

a. Very High Risk: Band 1 - 0.5% of Doncaster population
b. High Risk: Band 2 - 4.5% of Doncaster population
c. Med. Risk: Band 3 - 15% of Doncaster population
d. Low Risk: Band 4 - 80% of Doncaster population

The local approach to risk stratification is part of a direct enhanced service which requires the practice to identify the patients via a web reporting system and discuss the patient at an MDT (multi-disciplinary team). Patients identified as high risk are given a care package and are assigned to a healthcare professional.

Our Risk Stratification system is provided by NHS South London Commissioning Support Unit (previously known as East Sussex Health Information Service). Over the last 12 months we have implemented the web tool including the flow of secondary care data to the system provider as well as 121 training to our GP Practices. The data for risk stratification is downloaded by a DMIC seconded member of staff at Doncaster CCG and transferred to the team providing the system via an N3 (internal) upload facility. The members of staff at the provider are also employees of the DMIC. In the future we are looking at a direct transfer of data between the two DMIC centres.

Over the next 12 months, subject to national developments in Information Governance issues by DH, we intend to flow Primary Care data and Community data into the system to increase its accuracy and efficiency. Due to the current governance rules, the Risk Stratification system can only be used for direct patient care and is not available for use by the local commissioning organisations.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers.

Likelihood	Impact
A Very high	**1** Catastrophic
B High	**2** Critical
C Significant	**3** Marginal
D Low	**4** Negligible
E Very low	
F Almost impossible	

Risk	Risk rating	Mitigating Actions
Lack of meaningful engagement with Stakeholders, users and carers.	B2 at first cut D2 at second cut	The JACF have made significant progress since the first cut of the plan in formalising stakeholder engagement in the BCF, therefore the risk has been reduced. Formal links now agreed with Stronger Partnership programme Healthwatch Doncaster CVS New Horizons Doncaster Voluntary Sector health and Social care forum.
Development of plans to deliver some of the national conditions will take longer than the plan timetable allows	C2 at first cut stage D2 at second cut	The governance and planning structure is now in place and the Health and Wellbeing Board and the JACF are committed to the process. A dedicated Programme team will support the coordination delivery of the planning and delivery timetable.
Single commissioner and provider agency priorities and funding pressures affect the ability to agree on a joint plan and priority spend	C2 at first cut D2 at second cut	Outcome of Commissioner and provider discussions and key provider plans demonstrate a clear commitment to joint planning as well sharing ambition and vision for Doncaster services in the future.
Limitations on existing data systems, processes and information sharing protocols may impact on the extent of performance reporting and planning activity.	C2 at first cut C2 at Second cut.	The HWBB and JACF commitment to joint performance reporting and facilitating access to provider data sets has been agreed as critical. A joint performance group has been embedded into the BCF governance structure.

The impact on NHS providers is not fully known until the next stage of planning is complete.	C2 at first cut D2 at second cut	Dialogue with NHS providers has taken place and headline BCF vision and schemes agreed. Shared commitment to on-going impact and risk management has been agreed via the HWBB.
Limited knowledge on the impact of the scheme on the wider interdependent agencies.	D2	Phase 2 plan development and consultation processes are now agreed and will identify major risks and plans to mitigate risks.
Strong joint leadership is difficult to maintain	C2	A strategic Joint Commissioning forum has been agreed and will meet every 3 months to agree and mandate the scope and intent of the programme priorities.
Schemes do not realise expected benefits and impact on ability to shift resources into planned schemes	D2	Benefits realisation will be an early task of the 3 working groups to determine realistic ambitions of schemes. Sheffield University will include benefits realisation as an early capacity building skills need. A proportion of SMI programme allocation will continue to act as transformation monies to support transitional scheme plans and mitigate any negative consequences on acute provision.
Shift of resources without sufficient transitional planning may destabilise provision across the system	C2	Impact assessment will form part of the transitional arrangements for programme development
Capacity of the market to respond to significant changes in model of service delivery	C2	There is a commissioning focus on developing a strong market position statement which is continuously refreshed to respond to system changes