Doncaster Council

Report

Agenda Item No. 12
Date: 13 June 2019

To the Chair and Members of the
HEALTH AND WELLBEING BOARD

BETTER CARE FUND – BCF – 2018/19 QUARTER 4 UPDATE

Relevant Cabinet Member(s)	Wards Affected	Key Decision
Cllr Rachael Blake	All	No

EXECUTIVE SUMMARY

1.1 This report provides an update on the Quarter Four 2018/19 Statutory Return for the Better Care Fund – BCF. A comprehensive return was submitted with a good understanding of the current position, informed by the review of 42 BCF schemes carried out in Quarter Three and the Adult Social Care Peer Challenge in January 2019.

1.2 Partners represented at the Joint Commissioning Operational Group – JCOG - agreed that delivery of Doncaster's BCF Plan has improved joint working and has had a positive impact on the integration of health and social care.

1.3 Key points from the Quarter Four 2018/19 return are that the partnership continues to meet all the national conditions for BCF and was on track to meet the targets in three out of the four national indicators (Reduction in non-elective admissions, Reablement, Delayed transfers of Care), the exception being the Rate of permanent admissions to residential care (65+) which was not on track to meet an ambitious target. *See 5.3d and Appendix 1.*

1.4 Doncaster has progressed well in implementing the High Impact Change Model across health and social care, with six out of the eight changes reported as 'established' and 'plans in place' for the remaining two.

1.5 Key successes reported include:

- Improved joint working at the strategic level – reflected in Governance, Joint

Commissioning Strategy, joint agreements and joint outcomes framework;
- Increased integration at the operational level - two pilots involving multi-disciplinary teams are moving towards mainstream integration (Intermediate Care and Complex Lives);
- Seven Day working - Rapid Response, community and bed based Intermediate Care services accept referrals seven days a week. (The Doncaster Rapid Response Service case study was featured in the new NHS 10 Year Plan and was also recognised as an exemplar service in the 2019 Health Service Journal Value Awards);
- Joint commissioning arrangements have been strengthened - joint lead appointed for Children and Young People and very positive work in joint commissioning of post-diagnostic Dementia Support Services;
- Good prevention offer being delivered through Public Health and Stronger Communities/Wellbeing Team - Affordable Warmth, Move More, Well Doncaster.

1.6 Key challenges identified in project updates in 2018/19 were:
- Discharges creating displacement elsewhere in the system (i.e. in homecare);
- Realigning resources and moving investment to other parts of the system – as pilot projects demonstrate their effectiveness, recurrent funding is required to replace temporary funding;
- Information Governance – obtaining sign-off of information sharing agreements to enable the appropriate sharing of data (e.g. to support the tracking of patient journeys through various pathways to provide improved intelligence on a system-wide basis);
- Supporting the market to develop (A new market position statement is in development);
- Supporting the voluntary sector. (A project is currently underway led by the voluntary sector to design and implement a democratically elected co-ordination function which will enable the sector to connect with each other and Team Doncaster, due to report in September 2019.)

See Appendix 2 for full narrative provided in the return.

1.7 The final financial outturn position is summarised below.
See Appendix 3 for full details.

Funding	**Budget £'000**	**Outturn £'000**	**Variance £'000**
BCF - CCG	15,457	15,457	0
BCF - DMBC	7,302	7,302	0
iBCF	11,492	11,040	-452
Winter Pressures	1,510	1,510	0

The £452,000 underspend on iBCF will be carried forward to 2019/20 to help smooth the impact of the reduction in iBCF allocation, in line with the Council's financial strategy.

1.8 The National BCF Policy Framework for 2019-20 has been published but the planning requirements and CCG funding allocations are still awaited. As a result, the final local plan for 2019-20 will not be available for the June meeting of the Health and Wellbeing Board to consider and so arrangements for sign-off will need to be agreed. Nationally, 2019-20 is to be a year of minimal change for BCF and so locally it is proposed to continue existing

schemes.

1.9 A new Section 75 agreement for the pooled budget arrangements between the Local Authority and Clinical Commissioning Group is being produced reflecting recent changes to the governance. BCF progress and updates are being reported to the Joint Commissioning Operational Group – JCOG - with recommendations being ratified by Joint Commissioning Management Board – JCMB. Final responsibility for the sign off of the BCF Plan and Quarterly Statutory Return remains with the Health and Wellbeing Board.

1.10 National guidance has explained that any major changes to BCF will be from 2020-21 onwards. Existing schemes will be made aware of the potential changes in order that they can review implications for their service and staff, and develop an appropriate exit strategy. A number of schemes have been requested to provide an update on their performance, interdependencies with other projects and exit strategy to JCOG over the next six months, in readiness for funding announcements expected later this year.

EXEMPT REPORT

2. The report does not contain any exempt information.

RECOMMENDATIONS

3.1 That the Health and Wellbeing Board notes progress against the BCF national conditions, performance indicators, the final BCF outturn position for 2018/19 and general positive progress towards the integration of health and social care in Doncaster.

3.2 That the Board considers the challenges in delivering the Doncaster BCF plan and actions that could be taken to address these at the strategic level.

3.3 That the Board notes that a Doncaster BCF plan for 2019-20 and supporting Section 75 Agreement will be finalised as soon as funding allocations and planning guidance are received and agrees sign-off arrangements between Board meetings.

3.4 That the Board notes the action that is being taken to prepare for more major changes to the BCF anticipated for 2020-21 onwards.

WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

4. The Better Care Fund – BCF – is a key resource to enable health and social care integration and transformation of current services. Doncaster residents should expect to be supported to maintain their independence as long as possible and also see a more integrated, seamless response from health and social care partners. Doncaster residents should be able to plan their care with people who work together to support choice and control and bring together services to achieve the outcomes that are important to the individual.

BACKGROUND

5.1 The BCF is a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the

NHS and local authority which is then signed off by the Health and Wellbeing Board. The BCF encompasses a substantial level of funding in order to support health and social care integration. In 2018-19 this comprised:

Disabled Facilities Grant (Capital)	£2,500,475
Improved Better Care Fund	£11,491,740
CCG Minimum Fund Contribution	£22,758,655
Total BCF Pooled Fund	**£36,750,870**

Whilst not formally pooled as part of the Section 75 Agreement, the Winter Pressures Grant of £1,509,880 was also subject to the joint approval conditions outlined below.

5.2 The national conditions that the partnership must meet are:

a) Plans must be jointly agreed;
b) Planned contribution to social care from the CCG minimum contribution is agreed in line with the Planning Requirements;
c) Agreement to invest in NHS commissioned out-of-hospital services;
d) Managing transfers of care;
e) Funds are pooled via a Section 75 pooled budget arrangement;
f) Implementation of the High Impact Change Model.

5.3 There are four key BCF national indicators which must be monitored. At Q4 these were reported as follows:

a) Reduction in non-elective admissions – On track to meet target
There have been 4.7% fewer emergency admissions for patients aged 85+ and 6.2% fewer admissions due to falls for patients aged 65+ in April 2018-February 2019 than in 2017-18.

b) Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services - On track to meet target
The improvement in 2017-18 has continued in 2018-19. Additional homecare and community based capacity is enabling people to remain at home.

c) Delayed transfers of care – DToC – On track to meet target
Collaborative work across the health and social care community has resulted in a significant reduction in DTOCs. For April 2018-January 2019 DTOCs are 24.2% below the BCF target and 31.6% below the corresponding period in 2017-18.

d) Rate of permanent admissions to residential care (65+) – Not on track to meet target
Effective residential care resources panel has led to a significant reduction in admissions. However this was an ambitious target and admissions are monitored.

5.4 The High Impact Change Model – HICM - consists of eight system changes which have the greatest impact on reducing delayed discharge. Doncaster has progressed well in implementing the HICM across health and social care and the following changes are now established:

- Systems to monitor patient flow

- Multi-disciplinary/multi-agency discharge teams
- Home first/discharge to assess
- Seven-day service
- Focus on choice
- Enhancing health in care homes.

5.5 Two of the High Impact Changes have not progressed at as fast a pace in terms of being embedded within the system and the following are reported as 'Plans in place':

- Early discharge planning - There is currently a need to undertake further work around early discharge planning particularly with primary care to identify those who will require additional support following elective care and unplanned care;
- Trusted Assessors - There is currently limited buy-in from care homes for the Trusted Assessor model and this has resulted in it being challenging to progress. Discussions are taking place with local care homes to support and develop the model further. A Trusted Assessor (reviewer) model is being prototyped with one of our strategic local home care providers to review care packages and step up/step down where appropriate.

Funding has been secured from the Regional BCF Manager to work on these two changes with the Innovation Unit, which is currently providing support for the delivery of the Place Plan. The support includes workshops, deep-dive analysis and a visit to a best practice area.

5.6 **Key successes reported in 2018/19 include:**

- Improved joint working at the strategic level – reflected in Governance, Joint Commissioning Strategy, joint agreements and outcomes framework;
- Increased integration at the operational level - two pilots involving multi-disciplinary teams moving towards mainstream integration (Intermediate Care and Complex Lives);
- 7 Day working - Rapid response, Community and bed based intermediate care services accept referrals 7 days a week;
- Joint commissioning arrangements have been strengthened - a joint lead appointed for Children and Young People and very positive work in joint commissioning of post-diagnostic Dementia support services;
- Good prevention offer being delivered through Public Health and Stronger Communities/Wellbeing Team - Affordable Warmth, Get Doncaster Moving 'Move More', Well Doncaster.

5.7 **Key challenges identified in project updates in 2018/19 were:**

- Discharges creating displacement elsewhere in the system;
- Realigning resources and moving investment to other parts of the system;
- Information Governance – obtaining sign off of information sharing agreements to support the secure, lawful and appropriate sharing of data;
- Supporting the market to develop;
- Supporting the voluntary sector.

5.8 **Planning for BCF in 2019-20**

The Department of Health and Social Care and the Ministry of Housing,

Communities and Local Government published the 2019-20 Better Care Fund Policy Framework on 10 April 2019. 2019-20 is to be a year of minimal change for the Better Care Fund, prior to the outcome of the BCF review and the 2019 Spending Review. Any major changes will be from 2020-21 onwards.

5.9 The National Conditions are very similar to those in 2017-19. The national ambition for managing and reducing Delayed Transfers of Care (DToC) will continue. The BCF should continue to support the aim to reduce the number of patients who remain in acute hospitals for an extended period (21 days or more) by continuing to implement and embed the High Impact Change Model.

5.10 Expectations for local areas will continue to be set through the BCF and will be confirmed in the Planning Requirements but these have still not been issued. In the absence of the planning requirements, current schemes funded by BCF are being continued. A number of schemes have been targeted to provide an update to JCOG over the next six months on their performance, interdependencies with other projects and exit strategy, in readiness for announcements about BCF for 2020-21 onwards.

5.11 As it is anticipated that partners will be given six weeks to prepare plans and they will also go through a local assurance process prior to submission, local plans will not be available for the June meeting of the Health and Wellbeing Board and alternative sign off arrangements will need to be agreed.

5.12 Grant allocations to the Local Authority for Disabled Facilities Grant, Improved BCF and Winter Pressures Grant for 2019-20 have been confirmed as follows:

Winter Pressures Grant	£1,509,880
Improved Better Care Fund	£12,185,089
Additional Improved Better Care Fund	£2,135,843
Disabled Facilities Grant	£2,451,971
Total allocated to the Local Authority	**£18,282,783**

5.13 Section 75 Agreement

The existing Section 75 Partnership Agreement between Doncaster Council and Doncaster CCG, which sets out terms to maintain pooled funds relating to BCF and iBCF, expired on 31 March 2019. The refresh of this agreement has started, however the draft requires confirmation of the national funding allocations to the CCG, local plan and governance arrangements.

5.14 Governance

It is proposed that current arrangements continue; BCF progress and updates are reported to the Joint Commissioning Operational Group – JCOG - with recommendations being ratified by Joint Commissioning Management Board – JCMB. Final responsibility for the sign off of the BCF Plan and Quarterly Statutory Return remains with the Health and Wellbeing Board.

OPTIONS CONSIDERED

6. The delay in issuing national planning guidance and announcing grant amounts has meant that in the timescales available, there is little alternative to continuing existing schemes in 2019/20.

REASONS FOR RECOMMENDED OPTION

7. The limited timescales available to work with partners and the notice period that would be required to end contracts.

IMPACT ON THE COUNCIL'S KEY OUTCOMES

8.

	Outcomes	Implications
	Doncaster Working: Our vision is for more people to be able to pursue their ambitions through work that gives them and Doncaster a brighter and prosperous future; • Better access to good fulfilling work • Doncaster businesses are supported to flourish • Inward Investment	BCF supports the Well Doncaster project which supports people into employment.
	Doncaster Living: Our vision is for Doncaster's people to live in a borough that is vibrant and full of opportunity, where people enjoy spending time; • The town centres are the beating heart of Doncaster • More people can live in a good quality, affordable home • Healthy and Vibrant Communities through Physical Activity and Sport • Everyone takes responsibility for keeping Doncaster Clean • Building on our cultural, artistic and sporting heritage	BCF supports the Get Doncaster Moving 'Move More' project.
	Doncaster Learning: Our vision is for learning that prepares all children, young people and adults for a life that is fulfilling; • Every child has life-changing learning experiences within and beyond school • Many more great teachers work in Doncaster Schools that are good or	BCF supports projects to deliver the outcomes identified in the Doncaster Place Plan for children and young people.

	better • Learning in Doncaster prepares young people for the world of work	
	Doncaster Caring: Our vision is for a borough that cares together for its most vulnerable residents; • Children have the best start in life • Vulnerable families and individuals have support from someone they trust • Older people can live well and independently in their own homes	BCF supports projects to deliver the outcomes identified in the Doncaster Place Plan.
	Connected Council: • A modern, efficient and flexible workforce • Modern, accessible customer interactions • Operating within our resources and delivering value for money • A co-ordinated, whole person, whole life focus on the needs and aspirations of residents • Building community resilience and self-reliance by connecting community assets and strengths • Working with our partners and residents to provide effective leadership and governance	BCF supports projects to build community resilience. BCF is a key resource to enable health and social care integration and transformation of current services.

RISKS AND ASSUMPTIONS

9.1 National communications and workshops have explained that 2019-20 is to be a year of minimal change for the Better Care Fund. The national amount for BCF is similar to previous years and has been increased in line with average NHS revenue growth. On this basis, existing schemes are being continued for 2019-20 with an uplift for inflation where appropriate.

9.2 National guidance has explained that any major changes to BCF will be from 2020-21 onwards. Schemes will be made aware of the potential changes in order that they can review implications for their service and staff, and develop an appropriate exit strategy. A number of schemes have been requested to provide an update on their performance, interdependencies with other projects and exit strategy to JCOG over the next six months, in readiness for announcements later in the year.

LEGAL IMPLICATIONS

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

FINANCIAL IMPLICATIONS

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

HUMAN RESOURCES IMPLICATIONS

12. No HR implications have been sought for this update paper.

TECHNOLOGY IMPLICATIONS

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

HEALTH IMPLICATIONS

14. No Health implications have been sought for this update paper.

EQUALITY IMPLICATIONS

15. No Equality implications have been sought for this update paper.

CONSULTATION

16. Update papers are reported to Joint Commissioning Operational Group, Joint Commissioning Management Board.

BACKGROUND PAPERS

17. N/A

REPORT AUTHOR & CONTRIBUTORS

Olwen Wilson, Better Care Fund Project Manager
□□01302 735314 □□olwen.wilson@doncaster.gov.uk

Helen Rowlands, Finance Manager, Doncaster Council

Jonathan Briggs, Assistant Head of Performance and Intelligence, NHS Doncaster CCG

Name & Title of Lead Officer
Dr Rupert Suckling, Director of Public Health

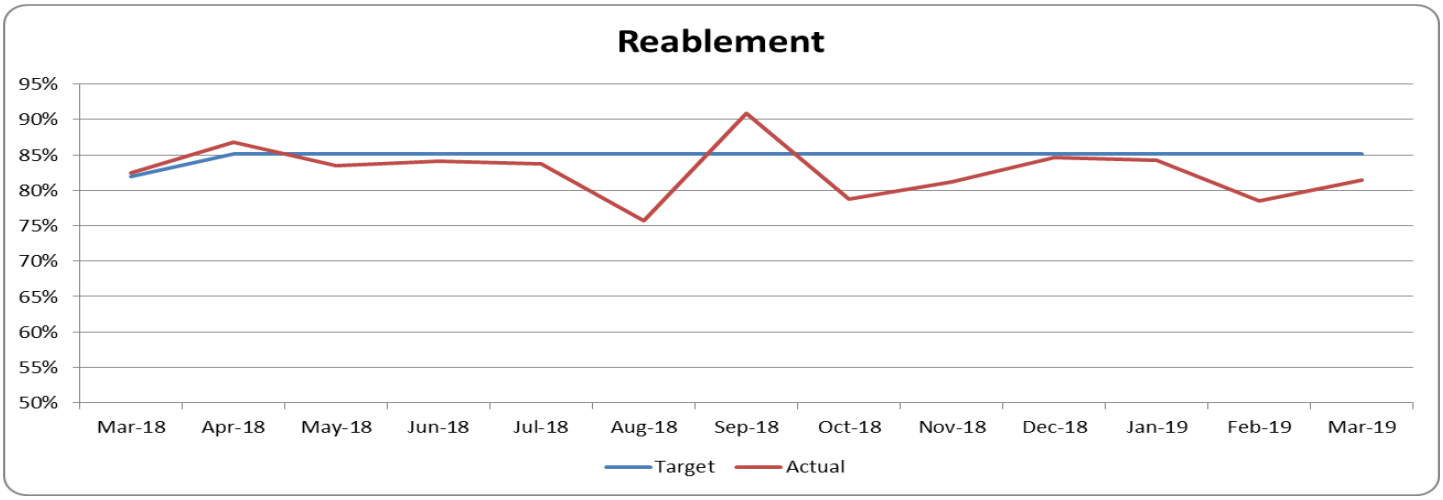
Appendix 1

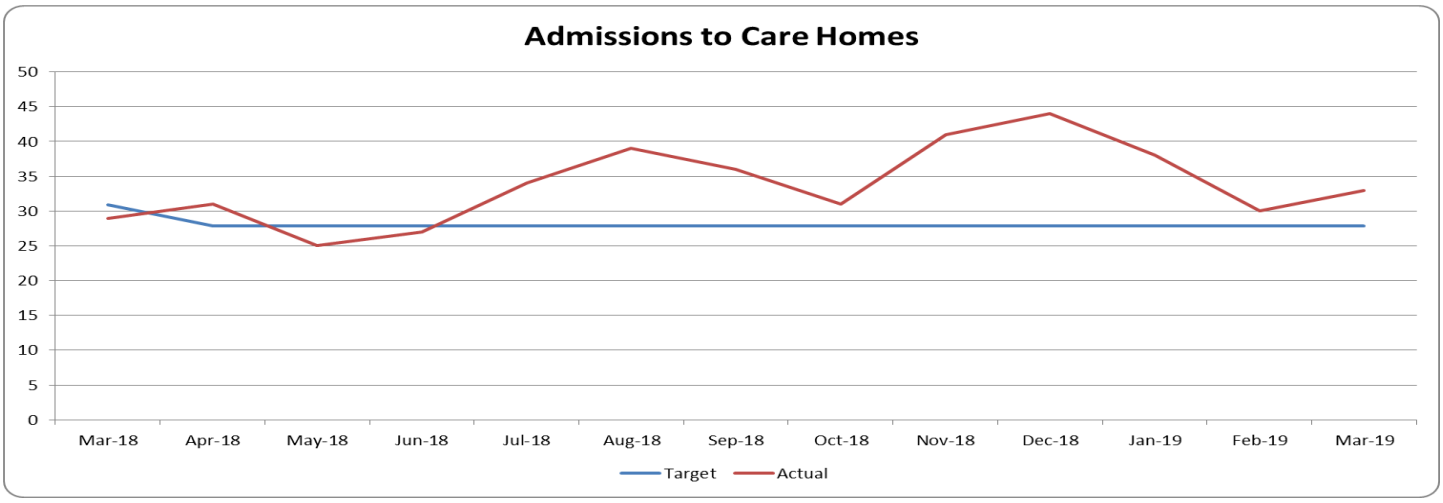
BCF National Metrics

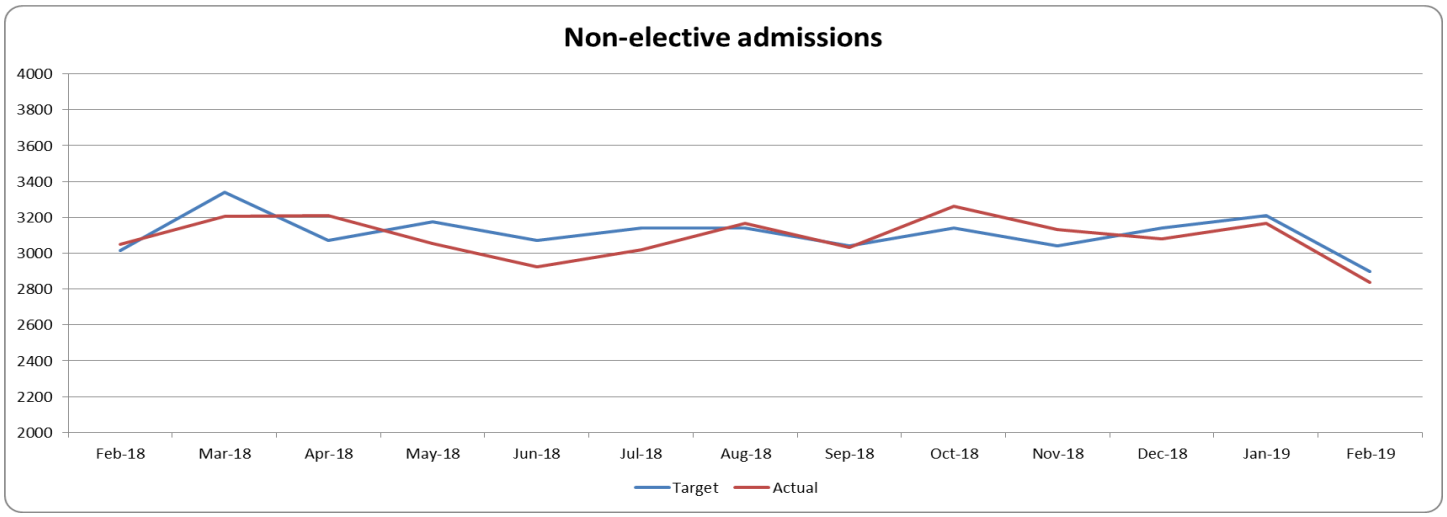
Year to date performance

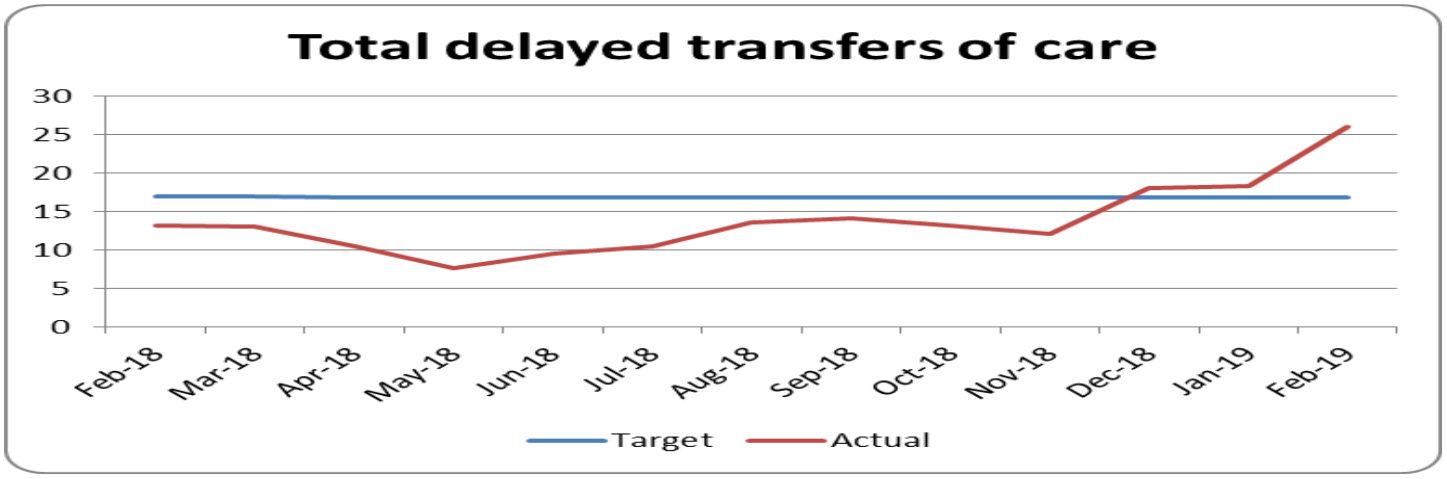
Metric	2018-19 target	2018-19 actual	Var.	2017-18	Var.
Reablement	85%	82.69%	-2.94%	81.49%	1.48%
Admissions to care homes	334	409	22.46%	403	1.49%
Non -elective admissions	34073	33885	-0.55%	34373	-1.42%
Delayed Transfers	5613	4629	-17.53%	6068	-23.71%
DTOC NHS	2251	2637	17.15%	1944	35.65%
DTOC ASC	1852	1237	-33.19%	2942	-57.95%
DTOC Joint	1510	755	-50.01%	1182	-36.13%

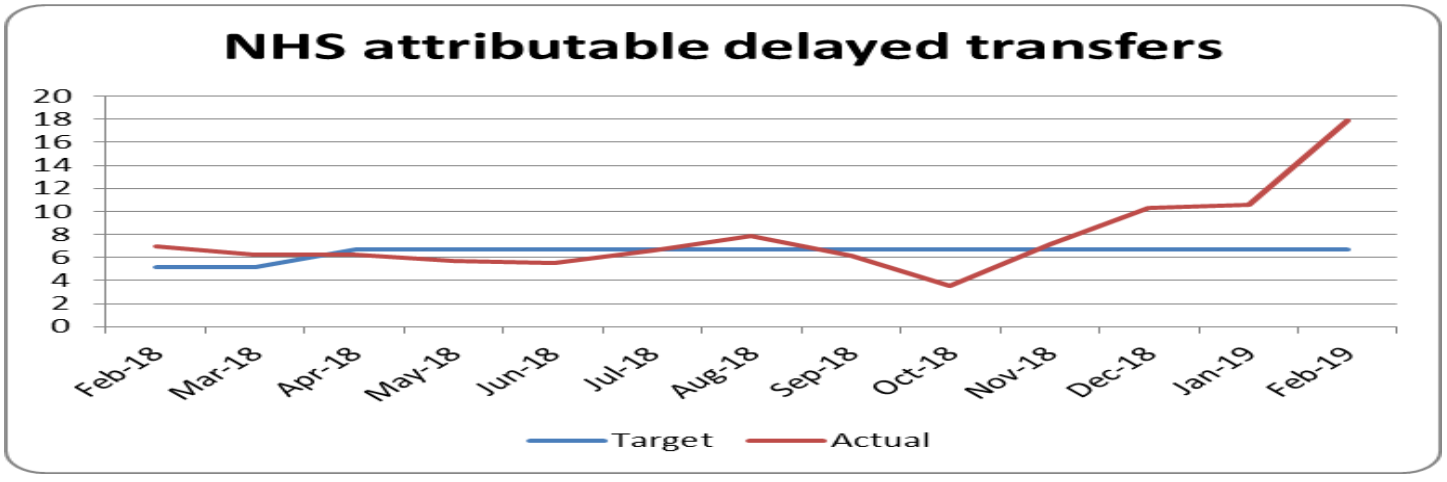
Monthly performance

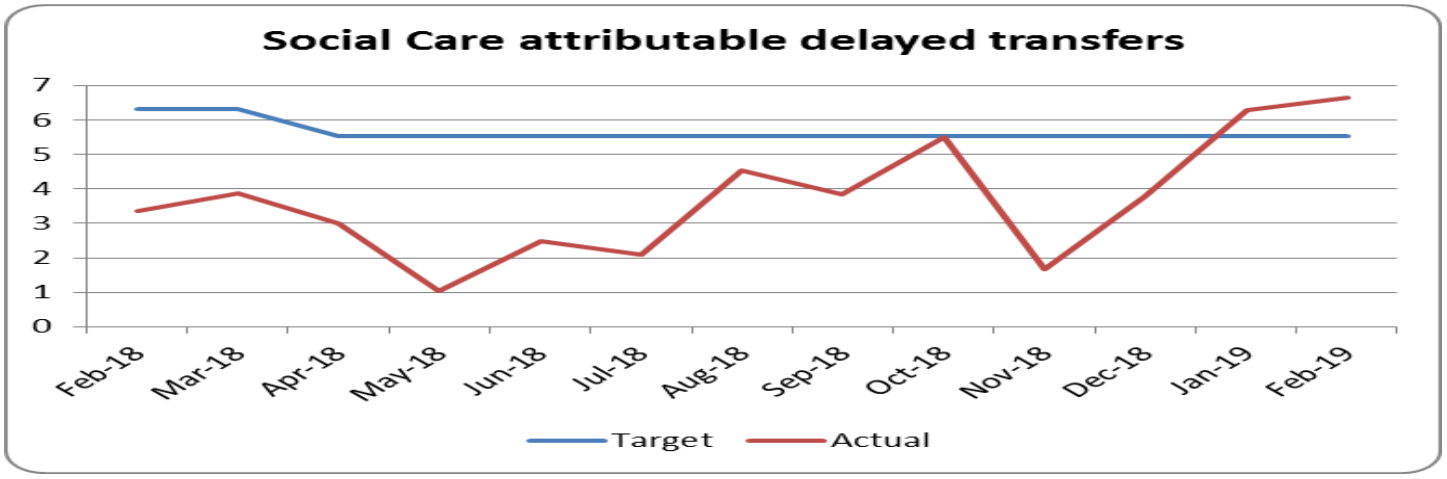


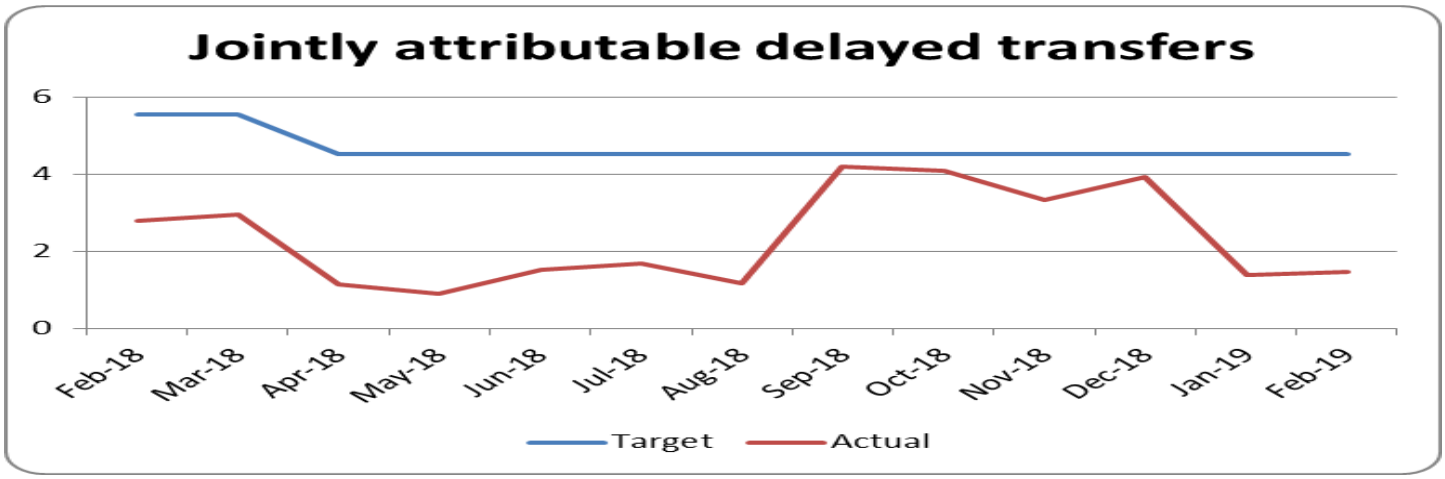



Non-elective admissions
4000
3800
3600
3400
3200
3000
2800
2600
2400
2200
2000
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Target
Actual


Total delayed transfers of care
30
25
20
15
10
5
0
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Target
Actual


NHS attributable delayed transfers
20
18
16
14
12
10
8
6
4
2
0
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Target
Actual


Social Care attributable delayed transfers
7
6
5
4
3
2
1
0
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Target
Actual


Jointly attributable delayed transfers
6
4
2
0
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Target
Actual

BCF 2018-19 Annual Update **Appendix 2**

Delivery of the Better Care Fund

	Statement	Response	Comment
1	The overall delivery of the BCF has improved joint working between health and social care in our locality	Strongly agree **Agree** Neither agree nor disagree Disagree Strongly disagree	Partnership governance is in place to deliver the Caring theme of the Borough Strategy, delivered through the Place Plan. The Doncaster Integrated Care Partnership Board leads the strategic development of the partnership, bringing together all Local Authority, housing and NHS organisations in Doncaster. The Joint Commissioning Management Board oversees delivery of the Joint Commissioning Strategy (CCG, Public Health, Children and Young People's and Adult social care) which is a major enabler of joint working. This is underpinned by a legally binding Joint Commissioning Agreement. A Provider Collaborative Agreement is also in place, delivered through the Provider Alliance overseen by the Provider Executive Group. The Health and Wellbeing Board oversee an integrated outcomes framework, delivered through Joint Commissioning and the Place Plan. Projects are working across numerous partners including Doncaster Council, Doncaster CCG, Rotherham Doncaster and South Humber NHS Trust, Doncaster and Bassetlaw Teaching Hospital NHS Trust, Primary Care, Doncaster Children's Services Trust, Yorkshire Ambulance Service and voluntary sector. Good examples of multi-disciplinary teams and what a collaborative approach can achieve are Intermediate Care Rapid Response and Complex Lives (also recognised by a recent Peer Challenge and

			highlighted elsewhere in this return.)
2	Our BCF schemes were implemented as planned in 2018/19	Strongly agree **Agree** Neither agree nor disagree Disagree Strongly disagree	Two pilots are now moving to mainstream provision and being used as proof of concept for multi-disciplinary teams, to be replicated in other areas. An in depth review of 42 schemes funded by BCF has been undertaken. A programme of scheme reviews has been developed to inform future integration initiatives.
3	The delivery of our BCF plan in 2018/19 had a positive impact on the integration of health and social care in our locality.	Strongly agree **Agree** Neither agree nor disagree Disagree Strongly disagree	Integrated, neighbourhood-based multi-disciplinary teams are being established, with prototypes around older people with frailty (Thorne) and early help for children and young people and their families (Denaby and Hexthorpe). The integrated Digital Care Record has helped enable joined up assessment and care planning and to support better decision making and manage risk as professionals can see who is involved in a person's care. Separate contracts for Dementia services have been brought together under one contract and specification. Providers have moved from a competitive to a more collaborative approach. A joint learning disability and autism strategy across the Council and CCG is also nearing completion.

4	The delivery of our BCF plan in 2018/19 has contributed positively to managing the levels of Non-Elective Admissions	Strongly agree **Agree** Neither agree nor disagree Disagree Strongly disagree	The BCF continues to provide support to the health and social care integration in Doncaster. 4.7% fewer emergency admissions for patients aged 85+ and 6.2% fewer admissions due to falls for patients aged 65+ Apr 2018-Feb 2019 than in 2017-18.
5	The delivery of our BCF plan in 2018/19 has contributed positively to managing the levels of Delayed Transfers of Care	Strongly agree **Agree** Neither agree nor disagree Disagree Strongly disagree	Collaborative work across the health and social care community has resulted in a significant reduction in DTOCs. For Apr 2018-Jan 2019 DTOCs are 24.2% below the BCF target and 31.6% below the corresponding period in 2017-18.

6	The delivery of our BCF plan in 2018/19 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Strongly agree **Agree** Neither agree nor disagree Disagree Strongly disagree	The improvement in 2017-18 has continued so far in 2018-19. The development of integrated intermediate care services, and integrated neighbourhood delivery will ensure that this continues to be strengthened and supports a decrease in DTOCs.
7	The delivery of our BCF plan in 2018/19 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)	Strongly agree **Agree** Neither agree nor disagree Disagree Strongly disagree	Effective residential care resources panel has led to a significant reduction in admissions (18% fewer in 2017-18 than 2015-16). The emerging new care model to support people with frailty more proactively will also have an impact on admissions to permanent care.

Success and Challenges

	Enabler	**Response (detail your greatest success/challenge)**
Success 1	Integrated electronic records and sharing across the system and with service users	The integrated Digital Care Record allows professionals to view what is happening with their patients. It has helped to change decision making and manage risk as professionals can see who is involved in a person's care.
Success 2	Strong, system-wide governance and systems leadership	Joint commissioning arrangements include the Council, CCG and Public Health. Commissioning for Children and Young People has a jointly appointed lead. Integration of children and young people's commissioning teams has been agreed for 3 test areas. Very positive work has taken place in joint commissioning of post-diagnostic Dementia support services. Joint Commissioning Agreements and Provider Agreements are in place. A joint Commissioning Strategy has been agreed by the CCG and Doncaster Council for 2019-2021; this is supported by jointly agreed delivery plans. Doncaster Integrated Care Partnership Board oversees whole system health and care strategy for Doncaster.
Challenge 1	Pooled or aligned resources	Some pilots have been tested, evaluated and implemented over a number of phases to prove concept, however it is proving difficult to realign resources and move investment to different parts of the system.
Challenge 2	Integrated workforce: joint approach to training and upskilling of workforce	Staff recruitment and retention, which affects the capacity to take on more referrals, and staff skills gaps are highlighted as a challenge for a number

		of interconnected projects. A Strategic Workforce and Education Committee is now in place to lead the development and implementation of a cross-system workforce strategy.

1 Progress against local plan for integration of health and social care (Significant milestones met, any agreed variations to plan, any challenges

Adult Social Care Peer Challenge January 2019

The recent Peer Challenge found there are good links with Public Health, the Police and other agencies; a strong neighbourhood focus and information sharing systems with Health. There is a Partnership Agreement in place and work is driven by a Joint Committee. CCG colleagues were particularly impressed with DMBC colleagues using the Place Plan to inform change to their work. The Peer Challenge also noted good use of external expertise to guide Doncaster on the improvement journey, e.g. Cormac Russell (Asset Based Community Development) and Professor John Bolton (managing demand).

Joint Commissioning

Joint commissioning arrangements have been strengthened through a formal joint commissioning agreement, which sets out clear expectations, roles and responsibilities across the whole system. Workshops have been held over the past 12 months which led to the development of the 'life stage' commissioning approach (Starting Well, Living Well and Ageing Well) which moves the commissioning partnership into a population health management approach. Joint commissioning arrangements include the Council, CCG and Public Health. Joint Commissioning Agreements and Provider Agreements are in place and a Joint Commissioning Strategy has been produced.

Commissioning for Children and Young People has a jointly appointed lead. Integration of children and young people's commissioning teams has been agreed for three test areas; First 1001 Days, Vulnerable Adolescents and Children with additional needs.

Very positive work has taken place in joint commissioning of post-diagnostic Dementia support services. All organisations have separate contracting arrangements, however they are all brought together under one overarching service specification for Post Diagnostic Services. Four additional contracts which deliver a Dementia Family Support Service will transfer to the CCG from 1 April 2019 and become part of the Accountable Care Partnership. Since 1 April 2018 partners have focused on developing partnership working and addressing cultural differences. Considerable progress has been made in terms of development of the model and also with the encouraging of partnership cohesion. Providers have moved from a competitive to a more collaborative approach. Partners have confirmed that they agree to a proportionate cost reduction to their contract values with no impact to current service provision.

Areas of Opportunity

Business cases for integrated models of care have been developed for *First 1001 days* and *Vulnerable adolescents*

Two pilots (*Intermediate Care Rapid Response* and *Complex Lives*) have tested new models of delivery and are now moving to mainstream provision. These approaches are being used as proof of concept for multi-disciplinary teams to be replicated in other areas. (See Integration Success Story below)

Learning Disability
A new Learning Disability and Autism strategy is in final draft ready to go through CCG and Council governance.

Dermatology
Clinical model endorsed by Clinical Reference Group.

Urgent and Emergency Care
- Good partnership and engagement work is moving forward
- Discharge: HomeFirst proposal further developed and costed
- Integrated Urgent Care (IUC 111) implementation is underway
- Work completed by RDaSH on the mental health pathway template to ensure that people can access the right local service first time
- System Perfect focussed around mental health delivered
- Development of Doncaster UEC Strategy and model underway
- Hospital/home interface workstream is being scoped

Prevention
A good prevention offer is being delivered through Public Health and Stronger Communities/Wellbeing Team. Well Doncaster is a pilot site for Well North, a strategic collaboration between local areas, Public Health England and Manchester University. In Well North Denaby, a local steering group is in place which includes local organisations that are set up to improve the wellbeing and health of people living in a former coal mining village. This scheme included "micro-grants" given out via Healthwatch to help people to become more active. 2018/19 has focused on moving the programme into four additional communities. Strategic and community partners have been engaged and community action plans developed for each area. Well Doncaster has supported and influenced partners' integrated area based working agenda and fed in to the delivery of Community Led Support and Social Prescribing projects. The project is also working in partnership with Sport England's Local Delivery Partnership and developing a community based approach to understanding physical activity to inform whole system change.

Neighbourhood Delivery
Joint locality multi-disciplinary teams are being established of professionals and non-professionals working together from a single location. This enables information sharing between disciplines and teams to deliver strengths-based and solution focused advice and interventions. Integrated Neighbourhood Developments are starting with an initial focus on the people who are frail and for children and young people and their families who can be directed to community-led support.

21 Community Led conversation points have been set up, operating at different times in our four localities, following the identification of "hot spot" locations.

Wellbeing Officer roles have been created to support the delivery of the Integrated Support and Assessment Team – ISAT. These roles are being used to enhance the ISAT model and provide a completely innovative new service with a 72 hour response, focused on:

- Prevention, diversion and targeted interventions to promote independence
- Developing knowledge, understanding and culture within customer services and ISAT around community offer and signposting opportunities
- Providing high quality, accessible and easy to understand information, advice and guidance
- Encouraging and supporting people to find their own independent solutions, making best use of all available local resources
- Provision of a 72 hour response, to identify "pinch" points in health and care delivery and to deliver quick low level interventions to prevent access to crisis/service or to enable a managed escalation into appropriate services, without crisis.

Building Community Capacity

Consultation has taken place with citizen leaders, practitioners, business and faith leaders and commissioners to embed Asset Based Community Development in communities across Doncaster. Five initiatives have been identified:

- Community builders: investment in small scale (not necessarily Third Sector Organisations) local community activities.
- Matching funds with effort/time in local communities
- Organisational development and training
- Assessment and case management systems that support an asset-based approach
- Asset mapping of local communities.

Equipment and Adaptations

Demand for use of assistive technology is on the rise. Installations of telecare equipment have increased 35% from the same period last year. Software has been upgraded to improve the quality of data going into the system and also enable mobile working for team members. An awareness campaign has taken place encouraging people to purchase equipment for themselves.

Discharges

A Discharge Passport is given to patients throughout the acute hospital when they arrive on the ward to consider plans for their discharge; work is underway to review how this can be used system wide. The protocol for making housing applications has been refreshed and updated by all partners and has been circulated to all staff to raise awareness of the pathway. Housing meetings have been established with key housing leads to progress housing issues. The Home First proposal has been further developed and costed. The High Impact Change Model is being implemented across the partnership.

Enablers

Doncaster Innovates (Innovation Academy) - The Innovation Unit and FutureGov have been commissioned to support Place Plan partners in Doncaster to develop their capacity and capability in the use of innovation techniques, delivered through a programme of action learning called Doncaster Innovates. This will provide challenge and support to services and organisations by bringing on board innovation frameworks and modern methods to support the integration of health and social care. The team has spent three months researching what innovation looks like in Doncaster now. Over the next three years, Innovation Unit and FutureGov will be providing coaching support to teams delivering innovation across Doncaster. Initially this is with teams developing approaches to early help and demand management in children and young people's services and in developing a best practice new care model to optimise care at home for people with frailty.

Estates – Initial programme scoping has commenced and the partnership will be developing a whole system strategy to optimise the estate across the partnership and to enable integrated neighbourhood delivery.

Digital and IT – The integrated Doncaster Care Record – iDCR - has helped to join up records to support integrated assessment, care management and delivery, also supporting better risk management as professionals can see who is involved in a person's care. A strategic lead is in post and scoping priorities with partners. Healthtrak is being used as a population health management tool to support whole system analysis. A number of benefits have been identified including the ability to track patient journeys through various pathways.

Whole system costing – A financial baseline and modelling tool has been developed to understand where costs lie across the health and social care system, divided into eight 'cost buckets' e.g. prevention, wellbeing, emergency care. This will enable future modelling of the impact of system changes across the integrated care partnership and give an indication of where investment needs to be made. It will provide a baseline to enable the Finance Working Group to set target savings for delivery. This will also provide a baseline to review any future service/business plans.

Workforce planning and OD – A Strategic Workforce and Education Committee has been established and will be supported by a partnership lead to develop the capability and capacity to deliver and embed the new model of care. They will:

- Develop a single Doncaster health and care workforce, OD and education strategy and delivery plan to support the delivery of the Place Plan, including the shared approach to:
    - Deep engagement of the workforce
    - Development of new models of leadership
    - Organisational development support
    - New roles and ways of working
    - Evaluation of impact and workforce implications
    - Workforce models and training for non-qualified staff
- Workforce and education representative at the Integrated Care System, Local Workforce Action Board and similar for Doncaster

- Development of capacity and demand tools across the health and care system to more accurately predict workforce requirements
- Work with local schools and colleges to develop apprenticeships and similar training opportunities locally
- Development of Integrated Care Partnership-wide training, education, development and career pathways opportunities to support staff to acquire new skills required to operate within the new care model for Doncaster, e.g. rotations across hospital and community services, NHS and social care settings

Business intelligence - The Council and CCG have developed shared reporting, use of shared systems and the ability to work across respective sites. The teams have also been integral to developing the outcomes for the life stages plans and the profiles for the integrated neighbourhood work.

Communications - CCG and Council Communication leads have been working closely to develop a joint communications strategy to support the joint commissioning arrangements. The joint approach to communications and engagement ensures a more co-ordinated and straightforward message to the public.

Challenges:

- Moving resources to invest in other parts of the system
- Acute bed pressures and number of patients requiring support for discharge
- Whilst admissions to long term residential care have reduced, this has created a displacement elsewhere (i.e. in homecare)
- Staffing pressures
- Information governance and delays in signing information sharing agreements
- Supporting the market to develop
- Convincing the workforce of the adaptability and safety of using digital solutions
- Uncertainty around the future of BCF funding and number of staff on fixed term/temporary contracts

Integration success story highlight over the past quarter (Nature of the service or scheme and the related impact)

Intermediate Care Rapid Response

The Intermediate Care Rapid Response Team has developed an extended pathway and access route. Any professional can refer to the service for any individual to prevent a hospital admission. A Multi-Disciplinary Team is providing support into Care Homes to assess and treat individuals who would otherwise have gone to the Emergency Department in an ambulance.

The Frailty Team is an MDT proactive approach to falls prevention. The service is Mental Health led due to the number of residents living with Dementia and mental health related conditions.

Over the past 12 months partners have continued to work together to test and begin to implement elements of the model with existing teams, preparing staff for transition and further involvement of patients and the public in refining the model. A number of test projects have been scoped by providers in response

to a series of challenges set by commissioners to encourage collaboration and test some of the aspiration around integration in the Doncaster place plan. These have included;

1. Simplifying access- Bringing together more access points in preparation for a place based Single Point of Access
2. Rapid Response and short term interventions - Delivering a multi-agency rapid response. Evaluation completed
3. Integrated rehab and reablement - Developing and testing an integrated reablement and rehabilitation pathway in preparation for transition to a single health and social care service model
4. Shared competency framework, carrying out a workforce audit and developing a joint workforce development plan
5. Integrated Doncaster Care Record - Proof of Concept
6. Integrated health and social care dashboard for intermediate care
7. Developing and testing a new integrated approach to commissioning, contracting and delivery.

Positive Steps – Social Care Assessment Unit

- The introduction of a dedicated Nurse from Rotherham Doncaster and South Humber NHS Trust, 5 days a week, to support with the complex issues , who links with the new GP surgery which is providing the staff and individuals with support to manage the health needs effectively and more efficiently. This intervention improves the outcomes for the individual, provides value for money, is more sustainable, and integrates further with health to improve services for older and disabled people. This also offers greater opportunities for individuals to be able to go back home and to increase their independence.
- The service has secured a permanent Physiotherapist from Doncaster and Bassetlaw Teaching Hospital NHS Trust who has added value to the team.
- Positive Steps is completing the falls assessment tool, which is a partnership tiered falls assessment to provide a standardised approach to assessing falls, and enables all levels to assess some level of risk and cause of falls. This form has been agreed as a single holistic tool for all partners to use in the community and bed based services.
- Positive Steps is about to commence the ARC (Achieving Reliable Care) project which is the first social care assessment unit to take part. It is a daily method of Multi-Disciplinary Team working which is purported to reduce length of stay by 20% and significantly reduce DTOC figures.
- Work with the Older People's Mental Health nurse to mentor and train staff to gain more insight and knowledge on mental health conditions and behaviours to alleviate the need for a contracted MH nurse presence

An options appraisal has been completed to redirect the resources from 20 beds into community services.

An evaluation of the Rapid response has been completed, which identifies:
Year on year services are experiencing increased referrals, due to the aging population and the increase of patients with long term conditions. Evaluation of the data collection has been considered against the number of Yorkshire Ambulance Service conveyances into the Doncaster Emergency Department. It is clear there is a direct correlation between the two. When the number of conveyances into ED increases, the number of referrals into the Rapid Response

pathway decreases. This is also true in reverse which suggests that where a conveyance to ED can be avoided by utilising the pathway the impact is an appropriate referral. This also suggests the early clinical conversation is effective by avoiding unnecessary conveyances where possible.

As the Rapid Response pathway has now been expanded into General Practitioners the numbers of referrals to avoid a hospital admission have increased but not all were appropriate for this pathway. Signposting of these referrals to the correct pathway has also increased but has allowed patients to receive care from the right pathway regardless of their entry point into the service.

For over 1000 referrals in to the Rapid Response service, 76% of people accepted were supported at home and 67% were still at home after 30 days. On average, unplanned acute admissions for people aged 65 and over have been lower in 2018-19 than in the previous two years. Conveyances to A&E, following a 999 response, for this group of people are higher than previous years, but those due to a fall are significantly lower.

The Doncaster Rapid Response Service case study was featured in the new NHS 10 year plan and has also been recognised as an exemplar service in the 2019 Health Service Journal Value Awards.

Complex Lives

Complex Lives is one of the areas of opportunity in the Place Plan, established to develop integration of health and social care services. It aims to provide wrap-around support for people who have become locked in a cycle of homelessness, rough sleeping, addiction, offending behaviour, poor physical and mental health – often underpinned by deep trauma. A joint agency agreement has been developed for homelessness and rough sleeping.

In Autumn 2018 it was reported that there were 110 cases on the Complex Lives cohort and that rough sleepers had spiked to around 67 in the summer, mostly in the town centre, although with very impressive intensive work of the Complex Lives Team and wider Alliance, this has now reduced to around 16.

The Complex Lives Team has created capacity to enable management of more complex cases. This has proved an important resource as existing services are not set up to deal with the complexity of issues involved. In the last six months the team has become more integrated and effective through:-

- Co-location with the Complex Lives team of St Leger Homelessness Single Point of Access;
- CCG/RDaSH commitment to appoint and embed a specialist Mental Health Nurse to Complex Lives team;
- DMBC Mental Health Social Worker aligned to team.
- DMBC Housing Benefits Officer seconded to team
- NACRO worker (offender support) seconded to team
- Doncaster Rape and Sexual Abuse Counselling Service trauma worker commissioned for one day per week

The housing protocol for homeless people has been refreshed and updated by all partners to ensure awareness is raised of the process and reduce delays in discharge.

Appendix 3

BETTER CARE FUND SUMMARY - OUTTURN UPDATE 2018/19

Project No.	Project Lead	Commissioning Lead	BCF Workstream	Plan 2018/19 £'000	Outturn 2018/19 £'000	Variance 2018/19 £'000	Comments on Variances
1	Anthony Fitzgerald	CCG	Community Aids and Adaptations	2,349	2,349	0	
2	Anthony Fitzgerald	CCG	Carers Support Services & Breaks	844	844	0	
3	Anthony Fitzgerald	CCG	COPD Early Supported Discharge (RDASH)	40	40	0	
4	Anthony Fitzgerald	CCG	Dementia Services (RDASH)	2,019	2,019	0	
5	Anthony Fitzgerald	CCG	Liaison Schemes (RDASH)	260	260	0	
6	Anthony Fitzgerald	CCG	Care Home Liaison (RDASH)	244	244	0	
7	Anthony Fitzgerald	CCG	Other Schemes ie Alzheimers & S256 contracts	205	205	0	
8	Anthony Fitzgerald	CCG	Clinical Services Review Community based services - Mex Mont re-design (RDASH)	1,144	1,144	0	
9	Anthony Fitzgerald	CCG	Assessment Unit Health Staffing	302	302	0	
10	Anthony Fitzgerald	CCG	Single Point of Access	473	473	0	
11	Anthony Fitzgerald	CCG	Respite Services (RDASH)	1,302	1,302	0	
12	Anthony Fitzgerald	CCG	Discharge Schemes inc Early Supported Discharge	834	834	0	
13	Anthony Fitzgerald	CCG	Bed Based Intermediate Care (RDASH)	3,419	3,419	0	
14	Anthony Fitzgerald	CCG	Mental Health Crisis Services (RDASH	2,022	2,022	0	
Total CCG share				**15,457**	**15,457**	**0**	
1	Clare Henry	DMBC	Falls Development Programme (Age UK)	50	50	0	
2	Lisa Swainston	DMBC	Round 2 Innovation Fund (Having a Good Day)	0	0	0	
3	Fay Wood	DMBC	Community capacity and well- being support / social prescribing	240	240	0	
4	Nick Germain	DMBC	Well North Project	167	167	0	
5	Fay Wood	DMBC	Community mobile day service / borough wide	125	126	1	
6	Fay Wood	DMBC	Dementia mobile day services	45	45	0	
7	Vanessa Powell Hoyland	DMBC	Winter Warm	85	79	-6	
8	David Eckersley	DMBC	Phase 1 Review officers	0	0	0	
9	Rosemary Leek	DMBC	Dementia Friendly Communities programme	0	0	0	
10	Rosemary Leek	CCG	Enhancement of Dementia support services (Alzheimers dementia café's)	77	77	0	
11	Rosemary Leek	DMBC	The Admiral service (making space)	88	88	0	
12	Louise Shore	DMBC	Hospital based Social Workers	213	176	-37	
13	Fay Wood	DMBC	Home from Hospital (Age UK)	70	70	0	
14	Collette Taylor	DMBC	Direct Payment Support Unit and Business Support Unit temporary staffing	118	47	-71	
15	Alan Wiltshire	DMBC	Integrated health and social care information management systems - (Caretrak)	50	50	0	
16	Rosemary Leek	DMBC	Dementia Advisor (Peer Support pilot)	0	0	0	
17	Sarah Sansoa	DMBC	Telecare Strategy	150	127	-23	
18	Rachael Thompson	DMBC	HEART	542	494	-48	
19	Rosemary Leek	DMBC	Dementia ccg post fully BCF funded	0	0	0	
20	Rosemary Leek	DMBC	Dementia Advisor (Age uk)	32	0	-32	
21	Rachael Thompson	DMBC	STEPS / OT service	1,510	1,377	-133	
22	Louise Shore	DMBC	RAPT	110	85	-25	
23	Rachael Thompson	DMBC	(Positive Steps) Social care Assessment Unit	1,724	1,962	238	Used BCF instead of £155k NR BCF (EMR) for DTOC additional posts
24	Louise Shore	DMBC	Hospital Discharge Worker	28	19	-9	
25	Rachael Thompson	DMBC	SPOC/One Point 1	92	66	-26	
26	Debbie John-Lewis	CCG	Intermediate Care and support strategy	170	170	0	
27	Fay Wood	DMBC	Mental Health - Doncaster Mind	245	222	-23	
28	Fay Wood	DMBC	Mental Health - Changing Lives	0	0	0	
29	Patrick Birch	DMBC	PMO (Programme Management Office and Development)	181	169	-12	
30	Andy Collins	DMBC	Alcohol Safe Haven	0	0	0	
31	Karen Tooley/ Ian Campbell	CCG	Doncaster Intermediate Health & Social Care – Phase 3- testing the model	0	0	0	

32	Patrick Birch	DMBC	Procurement of a strategic partner to support DMBC and partners across the Doncaster Health and Social Care sector to deliver the Doncaster Place Plan.	0	0	0	
33	Fay Wood	DMBC	Information and advice kiosks	0	0	0	
34	Vanessa Powell Hoyland	DMBC	Healthy homes healthy people	0	0	0	
35	Fay Wood	DMBC	Disabled Go	8	8	0	
36	Lisa Swainston	DMBC	Dev & Enhancement of vibrant provider market	0	0	0	
37	Simon Marsh	CCG	Integrated Digital Care Record Pilot – Consultancy Support	0		0	
38	Griff Jones	DMBC	Adults Health and Wellbeing – Creative Options for Learning Disability service users	673	780	107	
39	Griff Jones	DMBC	CLS Community lead support	500	608	108	
40			UNALLOCATED	10	0	-10	
Total - DMBC share				**7,302**	**7,302**	**0**	
Minimum CCG Contribution TOTAL				**22,759**	**22,759**	**0**	
1	Keith Sinclair	DMBC - DFG	Disabled Facilities Grants - capital funding	2,500	2,500	0	

IBCF SUMMARY UPDATE - OUTTURN 2018/19

Project No.		Commissioning Lead	BCF Workstream	Plan 2018/19 £'000	Outturn 2018/19 £'000	Variance 2018/19 £'000	
			Meeting Adult Social Care Need:				
1		DMBC	Increased Demands	3,509	3,500	-9	
2		DMBC	Residential Short Stay	600	600	0	
3		DMBC	Reducing Savings	1,115	1,115	0	
4		DMBC	Extra Care	200	0	-200	
5		DMBC	Money Management & DoLs/Safeguarding	258	188	-70	
			Reducing pressure on NHS:				
7		DMBC	BCF Projects - Transformation Programme	1,409	638	-771	Slippage
8		DMBC	Community Equipment	123	0	-123	
			Ensuring local supplier market is supported:				
13		DMBC	Contract Increases	4,279	4,999	720	Revised costings
	Grand Total of iBCF Plan			**11,492**	**11,040**	**-452**	It is planned to carry forward funding to 2019/20 to help smooth the impact of the reduction in iBCF allocation.
	Total iBCF			11492	11492	0	
	Balance b/f			1,322	1,322	0	
	Balance c/f			1,322	1,774	452	

NEW WINTER PRESSURES FUNDING PLAN

New Adult Social Care Winter Pressures Funding	Plan 2018/19 £'000
Single Point of Access Team - additional social work capacity at the front door	61
STEPS - additional social work and OT capacity	4
Dom Care Contract - price increase to match employment competitors	210
Short Stay/Respite	136
General Use of Social Care Funding	1,099
Total	1,510