Doncaster Council

Report

Agenda Item No. 12
Date: 5 September 2019

To the Chair and Members of the
HEALTH AND WELLBEING BOARD

BETTER CARE FUND (BCF) – 2019-20 DRAFT PLAN

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

EXECUTIVE SUMMARY

1.1 Final sign off of the Better Care Fund – BCF - Plan and subsequent Quarterly Statutory Return is the responsibility of the Health and Wellbeing Board. This report requests feedback on Doncaster's draft plan for the use of the Better Care Fund in 2019-20. The BCF Planning Requirements and Financial Allocations for 2019-20 were issued by the Department of Health and Social Care and the Ministry of Housing, Communities and Local Government on 18 July 2019 with a deadline for submission of 27 September 2019. BCF planning and reporting incorporates the Improved Better Care Fund - iBCF - and for the first time Winter Pressures Grant.

1.2 The financial allocations for Doncaster are as follows:

Funding source	**£**
Disabled Facilities Grant	2,451,971
Minimum CCG Contribution	23,546,940
iBCF	14,320,932
Winter Pressures Grant	1,509,880
Total	**41,829,723**

The minimum required to be spent from the CCG Contribution is:

NHS Commissioned Out of Hospital spend from the minimum CCG allocation – minimum required	6,691,373
Adult Social Care Services spend from the minimum CCG allocation – minimum required	7,774,610

1.3 **National conditions and requirements**

The BCF four national conditions and four national metrics remain the same. (See 5.2, 5.3). The main change is that separate narrative plans are replaced with a single template that includes sections covering:

- the local approach to integration
- plans to achieve the four national metrics
- plans for ongoing implementation of the High Impact Change Model for managing transfers of care.

It is expected local areas consider how provision across health, local government, social care providers and the voluntary sector can support the shared aims of providing better care at or close to people's home. There should be a clear focus on prevention and population health management.

1.4 **Submission Timetable**

Receive informal pre-submission feedback from Regional Assurance Panel	By 13 September
Final BCF submission from local Health and Wellbeing Board areas to be sent to the local Better Care Manager	By 27 September
Scrutiny of BCF plans by regional assurers, assurance panel meetings, and regional moderation	By 30 October
Cross regional calibration	By 5 November
Assurance recommendations considered by Departments and NHS England	5 – 15 November
Approval letters issued giving formal permission to spend	W/c 18 November
All Section 75 agreements to be signed and in place	By 15 December

The submission of Doncaster's BCF plan is being overseen by the Joint Commissioning Operational Group – JCOG – reporting to Joint Commissioning Management Board – JCMB. Consultation on the draft Winter Pressures Plan is being undertaken with wider partners through the Systems Resilience Group.

1.5 **Doncaster BCF Plan**

Given the delay in funding announcements, the majority of existing schemes have been rolled over into 2019-20 with an uplift for inflation where appropriate. It is proposed to allocate some of the additional funding received to Carers Support Short Breaks. The final plan is required to be submitted to NHS England on a spreadsheet template, however, for ease of review and comment, the key information has been extracted and attached as appendices:

Appendix 1 – Draft Strategic Narrative and impact on metrics

Appendix 2 – Financial Summary

1.6 **Planning for BCF in 2020-21**

It was understood that the national BCF team were proposing to make major changes to BCF from 2020-21 onwards. However, the National BCF Review has still not been published and the three-year Spending Review has been postponed until 2020 and replaced with a one year spending round. It is under these constraints that we are trying to plan ahead.

EXEMPT REPORT

2. The report does not contain any exempt information.

RECOMMENDATIONS

3.1 That the Health and Wellbeing Board comments on the draft Doncaster BCF Plan for 2019-20.

3.2 That the Board confirms sign-off arrangements of the final plan, pending feedback from regional assurance on 13 September, for submission by the deadline of 27 September 2019.

3.3 That the Board notes that a supporting Section 75 Agreement will be produced incorporating the final plan.

3.4 That the Board reviews progress of Doncaster's BCF plan for 2019-20 and evaluation of schemes at future meetings.

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.

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.

a) Reduction in non-elective admissions
b) Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
c) Delayed transfers of care
d) Rate of permanent admissions to residential care (65+)

5.4 The High Impact Change Model – HICM - consists of eight system changes which have the greatest impact on reducing delayed discharge:

1. Early discharge planning
2. Systems to monitor patient flow
3. Multi-disciplinary/multi-agency discharge teams
4. Home first/discharge to assess
5. Seven-day service
6. Trusted Assessors
7. Focus on choice
8. Enhancing health in care homes.

Health and Wellbeing Board areas should be able to confirm that each of the eight changes recommended are at least established by 31 March 2020.

5.5 Improved Better Care Fund – IBCF- is for adult social care and is for:

- meeting adult social care needs
- reducing pressures on the NHS, including supporting discharge from hospital
- ensuring the local social care provider market is supported.

5.6 Winter Pressures Funding is pooled into the BCF plans for the first time. The grant conditions require this is used to support the local health and social care system to:

- manage demand pressures on the NHS
- provide support for people to be discharged from hospital.

5.7 Disabled Facilities Grant – DFG – is a means tested financial grant to pay for essential housing adaptations to help disabled people stay in their own homes. DFG can be used to take a joined-up approach to improving outcomes across health, social care and housing.

5.8 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 local BCF plan.

OPTIONS CONSIDERED

6. The delay in issuing national planning guidance and confirming funding allocations has meant that 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 better • Learning in Doncaster prepares young people for the world of work	BCF supports projects to deliver the outcomes identified in the Doncaster Place Plan for children and young people.

	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 **Funding beyond 2019-20**

BCF provides substantial funding to enable health and social care integration and transformation of current services. The delay in announcements this year and uncertainty about 20-21 onwards means it is extremely difficult to plan ahead. General budget planning for 20-21 is already underway and assumptions are being made on the basis of having the same level of funding. As the Spending Review has been replaced with a one year spending round, one option for BCF could be to plan for 20-21 being another roll-over year. However this is a risk and other options need to be considered to mitigate this uncertainty. Some contracts with external providers will require six months' notice to end so de-commissioning of some services will need to start at the beginning of October 2019. Any evaluation of schemes would need to be completed before December to inform budget setting for 2020-21.

9.2 **Performance**

BCF is for integration and transformation. While there is uncertainty around funding there is a risk that integration across the system does not progress or mature at the pace required. As a result, there is a risk that the performance against the four BCF metrics does not meet the targets set. This would bring greater scrutiny of Doncaster's BCF plan.

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. Contained in the body of the report.

EQUALITY IMPLICATIONS

15. The supporting narrative in Appendix 1 sets out the approach for reducing health inequalities, supporting the housing needs of people with disabilities and alignment with wider strategies.

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

Contributors: BCF Steering Group, including representatives from commissioning, finance and performance from Doncaster Council – Kate Anderson-Bratt, Denise Bann, Helen Rowlands – and NHS Doncaster CCG – Jon Briggs, Ailsa Leighton, Tracy Wyatt

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

Section 4 - Strategic Narrative - DRAFT

Please outline your approach towards integration of health and social care. Please highlight any learning from the previous planning round (2017-19) and cover any priorities for reducing health inequalities under the Equality Act
A Person-centred outcomes *Your approach to integrating care around the person, this may include (but is not limited to):*

- *Prevention and self-care*
- *promoting choice and independence*

1500 words

Approach to integration

All major health and social care stakeholders recognise that in order to transform services to the degree required, a single shared vision and plan for the whole of Doncaster is necessary. This shared vision of health and social care has been articulated in the Doncaster Place Plan:

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

The Better Care Fund – BCF – is a key resource to enable health and social care integration and transformation of current services. Since the last BCF Plan was developed, considerable work has taken place across the Doncaster Health and Social Care Community to implement the vision for integration.

The Doncaster Place Plan identifies seven areas of opportunity:

- Starting Well (1001 days)
- Vulnerable Adolescents (Tier 4 Specialist Services)
- Urgent and Emergency Care
- Complex Lives
- Intermediate Care
- Dermatology
- Learning Disability and Autism

These are organised in three life stages – Starting Well, Living Well and Ageing Well.
Significant progress has been made in two areas of opportunity in particular - Intermediate Care and Complex Lives, both of which have been testing new approaches to multi-disciplinary teams and integration of services. These approaches are being used as proof of concept to be replicated in other areas. The longer term aim is that the models will be resourced through mainstream public service budgets, in recognition of the reductions in acute demand and cost savings produced. The BCF Plan for 2019-20 captures the learning from these projects to support the transition into mainstream services and support wider integration.
The Plan is also informed by a review of all existing BCF schemes undertaken in Q3 2018-19 and the Adult Social Care Peer Challenge in January 2019. As a result, some schemes were identified to provide more detailed updates. Further work will take place over Q3 and Q4 2019/20 to measure and evaluate the impact and effectiveness of these schemes, and to track cost benefits to inform future integration initiatives across Doncaster and, where appropriate, the wider South Yorkshire Integrated Care System.

The Doncaster Place Plan is currently being refreshed and will be finalised in early autumn. This will make population health profiles and population health management more explicit and will be structured around a four layer model:

- Community resilience
- Front door system
- Care and support at home
- Specialist services.

There are a number of existing areas of opportunity originating from the original Place Plan that will make a contribution to the emerging new model. The emphasis now is on bringing these into alignment with each other to create a coherent whole neighbourhood-based system for adults. These include:

- Intermediate care: short-term intensive and rehabilitative support to avoid unnecessary admission to hospital (step-up) and to ensure people regain their health, wellbeing and independence after a crisis (step-down)
- Frailty new care model: a prototype helping to shape integrated neighbourhood delivery, focused on people living with frailty and aiming to avoid or delay crisis though a more anticipatory and proactive integrated approach. This will bring together physical and mental health services for older people. The service is Mental Health led due to the number of residents living with Dementia and mental health related conditions.

A cornerstone of the refreshed Place Plan will be the development of neighbourhood-based health, care and wellbeing services and support, delivered as an all-age, integrated, person-centred model of care, dissolving professional and organisational boundaries. This will create a coherent, joined up approach centred on local people and their communities. This aligns with both the national ambitions set out in the NHS Long-term plan Implementation Framework and Team Doncaster's 'Doncaster Growing Together' local approach.

Person-centred outcomes

Doncaster is evolving a new practice model which focuses on strength based approaches across the health and social care partnership. Our vision is that everyone with a stake in ensuring people experience safe, appropriate and timely care and support in Doncaster is trained in a strengths based approach, understand the principles of personalisation and how these apply to their role. We will deliver, implement and embed a Practice Framework which describes how strength based approaches will be used in Doncaster. The framework will centre on Adult Social Care but will be used to influence practice across the Doncaster Place Plan. The focus will be on practitioners working with people on the basis of what is strong, not what is wrong. The approach operates on four levels:

- Individual level – working to help individuals and their families find solutions that build on their strengths and assets and personalise care according to need;
- Service level - building flexible, empowering and responsive services that are delivered in innovative ways;
- Community level - building and harnessing the strength of community organisations; delivery of integrated care through multi-disciplinary teams;
- System level - working collaboratively with colleagues across health and social care in the wider public, third and private sectors.

An example of a scheme which supports this approach is the Community Led Support programme. Community Led Support is a key principle of the social care transformation. This has as its vision local people, community groups and local partners all working together much more effectively with a common aim – to support people to live at home as part of their community, to be in control and be as independent as possible for as long as possible. Community Led Support involves the council and social care partnerships working together with their communities and staff, to provide support that responds to local needs and builds on local strengths and priorities. Community hubs have been created in each of the four areas to bring community groups and services together. People will have access to advice, information and guidance to build on their own and community strengths and self-help. Support for Carers and Mental Health are two service areas that have been co-produced using a community-led approach and will soon be delivered from the four community hubs that will bring community groups and services together. We will be having more conversations with communities to find out what is important to them, and how they want to be part of improvements in their community. Residents' priorities for the longer term are currently being captured through Team Doncaster's 'Doncaster Talks' consultation. External expertise has been brought in to guide Doncaster on the improvement journey, for example The National Development Team for Inclusion - NDTi - and Cormac Russell who has provided training in Asset Based Community Development and other strength-based approaches.

Prevention and self care

A good prevention offer is being delivered through Public Health and the 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 includes "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.

Assistive Technology
Innovation workshops have been held with the TEC Services Association – TSA – to work with Social Workers, OTs, ISAT and support staff to understand the range of Assistive Technology available. The aim is to promote the benefits of Assistive Technology to citizens and families and increase the range and volume of Assistive Technology being provided. There needs to be a strong connection to the front door teams, strength-based conversations and Information Advice and Guidance. Awareness raising will be carried out including for self-funders and carers. Work in this area brings together a number of partner initiatives including St Leger Homes and NHS Digital champions. Doncaster is part of a regional initiative to improve access to the internet. This would enable more households to take advantage of Assistive Technology.
Schemes supporting this section:
Carers Support Services
End of life Domiciliary Care
Home Emergency Alarm Response Team
Telecare Strategy
Community Mobile Day Service
Creative options for Learning Disability Service users
AccessAble
Move More Doncaster – Falls Prevention
Affordable Warmth
Well Doncaster

1427 words

B i Approach to integrated services at HWB level (and Neighbourhood where applicable), *this may include (but is not limited to):*

- Joint commissioning arrangements
- Alignment with primary care services (including Primary Care Networks)
- Alignment of services and the approach to partnership with the Voluntary and Community Sector
800 words

Joint Commissioning arrangements
Very positive work has been taking place for example:

- Joint lead appointed for Children and Young People; Integration of children and young people's commissioning teams agreed for three test areas; First 1001 Days, Vulnerable Adolescents; Children with additional needs.
- Separate contracts for post-diagnostic Dementia support services brought together under one contract. Providers have moved to a more collaborative approach through an Accountable Care Partnership.
- Complex Lives - an innovative 'whole system' model for people affected by multiple disadvantage.

Projects are working across numerous partners including Council, CCG, Health, Doncaster Children's Services Trust, Ambulance Service, Criminal Justice, VCF. Local intelligence is feeding into commissioning intentions.

Neighbourhood approach
The new operating model is set within the context of a 'Team Doncaster' whole partnership model of locality working. Doncaster is divided into four neighbourhoods to enable services to be tailored to local needs and delivered locally. The neighbourhoods are the basis of integrated services for many social care and health services. Staff and service users are shaping how the service works best at a community level. The neighbourhood approach gives a focus on the individual, family, friends, communities and primary care with a shift to more prevention and early intervention.

Joint locality multi-disciplinary teams are being established of professionals and non-professionals working together from a single location. Integrated neighbourhood developments have an initial focus on frailty and children and young people and their families who can be directed to community-led support. Wellbeing Officer roles have been created to support the delivery of the Integrated Support and Assessment Team.

Alignment with Primary Care Networks

Care in Doncaster is already provided in a way that aligns with the formation of Primary Care Networks – PCNs. Five PCNs have been established: North, South, East, Central and 4 Doncaster, which sit within the existing four neighbourhoods and are the cornerstone of integrated neighbourhood working. The 4Doncaster PCN already has clinical pharmacists in post to help people in a range of different ways. This includes carrying out structured medication reviews for patients with on-going health problems and improving patient safety, outcomes and value through a person-centred approach.

Each PCN will also be able to have a dedicated Social Prescribing Lead which will ultimately help patients live fitter, healthier lives and combat anxiety, loneliness and depression.

PCNs will continue to develop at pace, with expanded neighbourhood teams developed in partnership with patients, members of the public and local organisations.

Partnership with the Voluntary Sector - VCF

Doncaster's Place Plan is predicated upon early intervention, prevention and community-led support services. The VCF sector has a huge role to play in this, however Doncaster's VCF sector currently has no central co-ordinating function with which commissioners can engage.

Over the past six months, the CCG and Council have been working with the local VCF sector to explore how they can better work in partnership to deliver health and social care outcomes and address some of the issues Doncaster is facing. Representatives of the VCF Sector are currently working to develop and recommend a new democratic structure for the VCF and a plan for how this will be sustained. This is due to report in September 2019.

Intermediate Care Rapid Response

This is working across the council and health partners, Yorkshire Ambulance Service and the Voluntary Sector. BCF funding has been used for building the programme team, test and redesign the model. 1000 case audits have been undertaken to provide evidence of impact.

An extended pathway and access route has been developed. Any professional can refer to the service 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.

Workshops have been held to review the wider flow in and out of Intermediate care beds can be improved and mapped. Further workshops are planned to review and redesign Integrated Discharge Teams across all partners.

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;

- Simplifying access in preparation for a place-based Single Point of Access
- Multi-agency Rapid Response and short term interventions
- Integrated rehabilitation and reablement pathway
- Shared competency framework - developing a joint workforce development plan
- Integrated Digital Care Record
- Integrated health and social care dashboard
- Developing and testing a new integrated approach to commissioning, contracting and delivery.

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.

Schemes:
Community Led Support
Home from Hospital

Single Point of Contact
Integrated Discharge Team
795

ii Approach to integration with wider services, (eg housing), this should include:

- *Your approach to using the DFG to support the housing needs of people with disabilities or care needs. This should include any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the Regulatory Reform Order (2002)*
  800 words

Disabled Facilities Grant

The Doncaster Integrated Care Partnership Board brings together Local Authority, Housing and NHS organisations in Doncaster.

As Disabled Facilities Grant – DFG - is a key link to join up policy and operational issues and promote integration between OT and Housing, workshops are being held to consider more innovative ways of using DFG to support integrated discharge and bring good practice from elsewhere. It is proposed to make the process more flexible and less bureaucratic, especially for smaller grants below £5,000. Colleagues in Public Health are keen to build on the Affordable Warmth project, which supports the preparedness for winter weather and helps households experiencing the impacts of a cold, damp, unhealthy home. Schemes funded by DFG bring together social care, health, public health and housing in relation to the wider determinants of health including fuel poverty which can be a factor in excess winter deaths. Reducing excess winter deaths is a key policy priority for the Mayor of the Sheffield City Region. A review of local DFG policy in 2019-20 will lay the foundations for 2020 onwards.

Wider services

Complex Lives works with people affected by multiple disadvantage including rough sleeping , drug and alcohol addiction, offending behaviour, mental ill-health and poor physical health. The Complex Lives model is an example of an integrated, person centred approach for people within supported accommodation. The Complex Lives model has integrated wider services including health and social care, drug and alcohol services, mental health, housing, police and criminal justice system and the VCF sector. The next stage of development includes working on a managed shift from hostels to a greater focus on dispersed accommodation. A joint agency agreement is in development for homelessness and rough sleeping, including intensive wrap around support models and a Doncaster 'Housing First' offer. This is delivered through an Accountable Care Partnership approach. The project recently received the prestigious MJ Award for Care and Health Integration.

There are other examples how across the system Doncaster is embracing integration and developing good practice which can be learnt from:

Learning Disability and Autism

An overarching "all age" joint strategy for people with Learning Disabilities and/or Autism has been produced. The strategy ensures that there are clear joint principles and priorities for delivery and service improvement. Delivery plans and structures are currently being developed for implementation. Work streams have been established for housing, short breaks, transitions and health. This has identified priorities for joint working around education, health, housing and employment.

Mental Health

In Mental Health, a new focussed integrated team has been implemented. Social workers are now based in the Rotherham Doncaster and South Humber NHS Foundation Trust area teams to achieve social care outcomes for individuals, families and wider support networks.

Safeguarding

Discussions are taking place around development of an all age safeguarding Multi Agency Safeguarding Hub across Doncaster to build on the existing good work in this area. This involves Doncaster Council, NHS Doncaster CCG, Health Providers and the Police.

Work with the Innovation Unit

Doncaster is working in partnership with the Innovation Unit to provide challenge and support to Team Doncaster services and organisations by bringing on board innovation frameworks and modern methods to support the public service reforms in Doncaster Growing Together.

The partnership is one of "learning by doing" where capacity is built at every stage with the expectation that Team Doncaster's representatives will be the ones doing the 'heavy lifting' of the work required. It is a facilitation and coaching role rather than an outsourcing model and the Place Plan and Team Doncaster are partners in, not recipient of, pieces of work.

By using insight techniques to focus on citizen needs and assets rather than service needs, it is expected (and shown in previous innovation projects) that services are more coherently and appropriately designed. This in turn manages demand as services are designed in a way that is relevant and suitable for people's needs – encouraging early and better engagement and self-motivation/self-management.

659

C System level alignment, for example this may include (but is not limited to):

- *How the BCF plan and other plans align to the wider integration landscape, such STP/ICS plans*
- *A brief description of joint governance arrangements for the BCF plan*

1500 words

South Yorkshire and Bassetlaw Sustainability and Transformation Plan

There are 25 partners in the South Yorkshire and Bassetlaw Sustainability and Transformation Plan – STP - which sets out the vision, ambitions and priorities for the future of the region's health and care. The goal is for everyone in South Yorkshire and Bassetlaw to have a great start in life, with support to stay healthy and live longer. Prevention is at the heart – from in the home to hospital care. The STP focuses on people staying well in their own neighbourhoods and links up with the Doncaster Place Plan, recognising what can be delivered on a wider footprint and what can be delivered at place. The STP and the Doncaster Place Plan focus on early intervention and prevention, building on individual, family and community strengths and resilience. The South Yorkshire and Bassetlaw STP response to the Long Term Plan is currently being drafted.

Doncaster State of the Borough Assessment

Doncaster's State of the Borough assessment provides an overview of the quality of life in Doncaster now, how it is changing and how it compares to other similar places. It provides a solid platform upon which Team Doncaster can agree priorities, make the very best of available resources and assess the difference we are making over time. The assessment draws upon and inspires new enquiries from existing analysis in separate thematic assessments and reports, for example the Joint Strategic Needs assessment for the Health and Wellbeing Board.

Health and Wellbeing Board Strategy

The Doncaster Health and Wellbeing Strategy promotes integration and joined up commissioning across the NHS, Local Authority, Public Health and key stakeholders, supporting joint commissioning and pooled budget arrangements. Having the right choices, support and interventions in place at the right time in life means individuals will have every opportunity to improve their health and wellbeing. Choice and control is a one of three outcomes of the Health and Social Care Transformation programme which is the Doncaster approach to embedding person-centred integrated care. Integration of drug and alcohol services is also a priority, evidenced in the focus on Complex Lives.

Reducing Health inequalities is a key theme of the Strategy. Targeted asset based actions are being made in geographical areas where the inequalities gap is greatest, for example through the Well North initiative. A comprehensive needs assessment has been developed for the veterans community. A number of issues have been raised from asylum seekers and refugees which are being explored as well as improving access to services for all minority groups through dedicated workstreams.

Joint Commissioning Strategy

A Joint Commissioning Strategy has been agreed by the NHS Doncaster CCG and Doncaster Council for 2019-2021; this is supported by jointly agreed delivery plans. The Joint Commissioning Strategy is supporting the delivery of integrated health and social care through:

- taking a holistic approach to care and support
- person centred approach to support complex needs
- rapid response for those in crisis.

The strategy supports one integrated commissioning model, with a standardised approach across Doncaster Council and NHS Doncaster CCG. The aim is to provide person-centred, flexible, integrated care and support in people's own homes that aims to maximise their health and independence.

A culture is developing that facilitates integrated working and empowers staff. Integration is already evident in:

- neighbourhood teams
- urgent care
- voluntary and statutory offer
- Doncaster Care Record.

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

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

As part of the development of Doncaster's first joint health and social care commissioning strategy, we engaged with almost 800 people to seek their view on how Doncaster CCG and Doncaster Council should plan services together. The Joint Commissioning Strategy 2019-21 sets out the key focus and commitment for joint commissioning. The strategy has been jointly produced by health and social care and sets out how our collective action can make the most impact, moving further towards the joint vision of the Place Plan. The strategy sets out our joint commissioning journey for the next two years to enable us to undertake the next steps to:

- Work closely with local communities and neighbourhoods
- Ensure coordinated access
- Deliver a more holistic approach to care and support
- Provide care and support for individuals when they are in crisis
- Improve support for people with complex needs.

The Joint Commissioning Strategy sits across both health and social care, including Public Health, for adults and children. It captures the services commissioned by both Doncaster Council and NHS Doncaster CCG, with a particular focus on the areas where we will jointly commission together. This is supported by jointly agreed delivery plans.

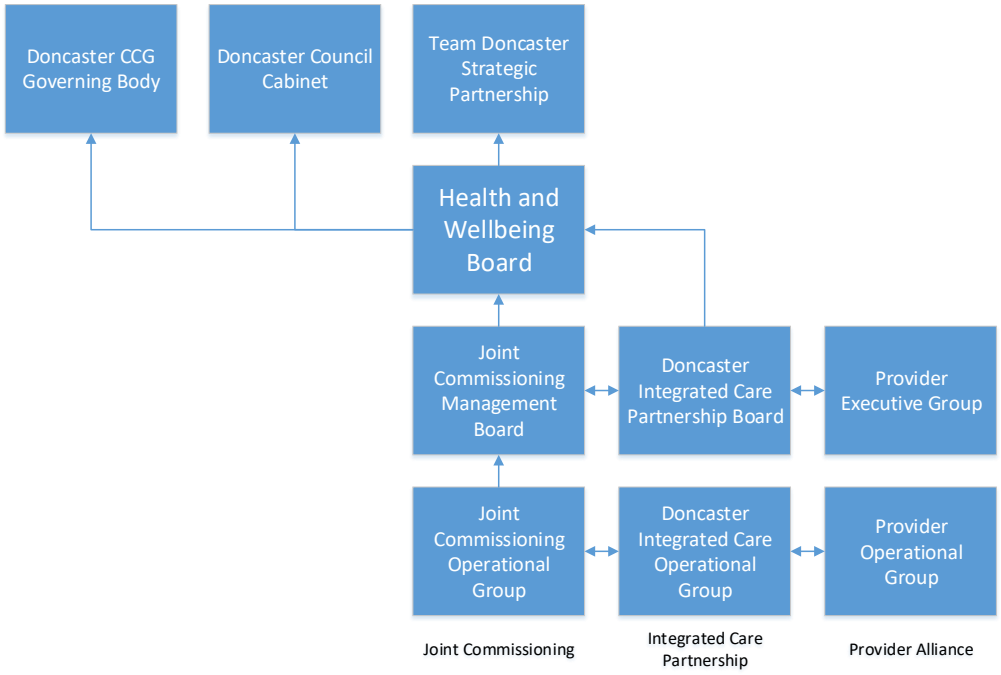
We have made some significant strides over the past 12 months. Workshops have been held which led to the development of the 'life stage' commissioning approach (Starting Well, Living Well and Ageing Well) which moves the commissioning partnership into a population health management approach. An early focus has been on post-diagnostic Dementia support services and Complex Lives. A Joint Commissioner is in post for Children's Strategic Commissioning and Transformation. Joint leads are proposed for Living Well (Learning Disability and Autism) and Ageing Well.

Population Health Management

We are using a Population Health Management approach to identify how we need to target our commissioning across the life stages and within our neighbourhoods. The intention is to build on a standard offer for all our population by identifying specific challenges at neighbourhood level, using new combinations of data and lived

experience, to identify and deliver targeted interventions. This can be used to help personalise care at the individual level, but also support targeted delivery at the neighbourhood level, inform integrated care design at the place level and strategic planning of system-wide services.

Governance arrangements



The Joint Commissioning Management Board oversees delivery of the Joint Commissioning Strategy. Joint commissioning arrangements have been strengthened through a formal joint commissioning agreement which sets out clear expectations, roles and responsibilities across the whole system. A Provider Collaborative Agreement is also in place, and Providers are working together overseen by the Provider Executive Group.

The Health and Wellbeing Board oversee an integrated outcomes framework, delivered through Joint Commissioning and the Place Plan.
In line with the Joint Commissioning agreement, it is proposed to expand joint governance mechanisms to include a broader range of services wider than the seven areas of opportunity, building on the work already done in Starting Well.

Management of the BCF is by the Joint Commissioning Management Board – JCMB. This group includes the Chief Executives and other senior officers of both DMBC and NHS Doncaster CCG. JCMB 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. JCMB is supported by the Joint Commissioning Operational Group which scrutinises all business case proposals and makes recommendations to JCMB.
1167 words

Section 7 - High Impact Change Model
Explain your priorities for embedding elements of the High Impact Change Model for Manging Transfers of Care locally, including:

- *Current performance issues to be addressed*
- *The changes that you are looking to embed further – including any changes in the context of commitments to reablement and Enhanced Health in Care Homes in the NHS Long Term Plan*
- *Anticipated improvements from this work*

The HICM provides an approach to enable change on a system wide basis from prevention through to discharge by managing patient demand and flow across the health and social care system as a whole. The principles of home first, discharge to assess and the role of the community and voluntary sector under-pin the HICM and closely align with the emerging Place Plan themes as the Place Plan refresh work continues.

There are strong links and interfaces with a number of current Place Plan work streams and/or planned areas of work which includes:

- Integrated area based working
- Intermediate care/rapid response
- Working towards a single point of access/'front door'
- Development of an integrated discharge hub (Community Single Point of Access) to ensure people get to the right place at the right time
- Working towards a single assessment
- Urgent and emergency care
- Out of hospital, home-based care including an integrated frailty model
- Planned and unplanned hospital care
- Development of a Multi-Age Safeguarding Hub
- Early Intervention and Prevention
- Embedding Asset Based Community Development within service delivery

The Doncaster health and social care community has taken a system wide approach to managing Delayed Transfers of Care - DTOC, reducing Length of Stay – LOS - and implementing the High Impact Change Model - HICM. This reflects inter-relationships between the actions for each workstream. Improvements have already been made in both DTOCs and LOS, and the key priorities for 2019-20 are:

- Early Discharge Planning – there is a need to undertake further work in this area, particularly with primary care and community services to identify those who will require additional support following elective and unplanned care. Care Homes need to plan in advance for residents who require elective care to ensure timely discharge and to ensure that support is in place in the community.
- Trusted Assessors – whilst we are in the process of prototyping a variation of the trusted assessor model with a strategic local provider for home care support, there is a need to roll out and test the prototype to enable us to manage transfers of care more effectively across the health and social care system.
- Enhancing housing pathways
- Further focussed enhancements to seven day services
- Reviewing bariatric requirements.

A detailed action plan to progress each of these areas has been agreed across the health and social care community, and can be provided if required.

The HICM is a critical element of our intermediate care Home First community model and bed based services and will contribute to the overall success of our integrated outcomes framework for the Intermediate care service. It will ensure that people are supported to maintain their independence and live at home preventing admissions to acute care and are supported to return home as early as possible. It will reduce the number of people requiring long term care and more people will remain at home following an episode of intermediate care. When intermediate care is needed people will receive a simple, responsive and flexible service and people who use Intermediate care will receive a holistic integrated service resulting in improvements to their functioning and quality of life following involvement in the episode of care.

As a result of the current Place Plan refresh work, the implementation of the HICM is of critical importance in the wider context of the health and social care integration agenda. This piece of work will include;

- A series of engagement workshops with health and social care providers, professionals, service users and carers to obtain buy-in from stakeholders
- The Innovation Unit supporting us to facilitate a "deep dive" of the HICM to obtain the current level of progress across the system as a whole and where challenges exist
- A deep dive into the reasons for our LOS performance

- The Innovation Unit providing expertise to identify tangible, focused solutions that are informed by best practise such as the South Warwickshire Model to ensure we meet the criteria for the HICM within the BCF national guidance
- An 'appreciative inquiry' being undertaken including a site visit to an area that is progressing well with the implementation of HICM changes
- Learning being captured and made available to share at a local, regional and / or national level
- Supporting the project leads to establish a successful approach to implementation
- Alignment with key projects within the refreshed Place Plan including: intermediate care, frailty, urgent and emergency care, integrated neighbourhood teams linked to emerging primary care networks and enhanced health in care homes

737 words

For each change, enter current position of maturity and maturity level planned to be reached by March 2020

- *Not yet established – if so, state reasons*
- *Plans in place*
- *Established*
- *Mature*
- *Exemplary*

Early discharge planning	Established
Systems to monitor patient flow	Established
Multi-disciplinary/Multi-agency discharge teams	Established
Home first/discharge to assess	Established
Seven day service	Established
Trusted assessors	Established
Focus on choice	Established
Enhancing health in care homes	Established

Section 8 - National Metrics

Target

Metric	**18-19**	**19-20**
Total number of specific acute non-elective spells per 100,000 population	Not collected on this template	
Delayed Transfers of Care per day from hospital (aged 18+)	16.8	16.7
Long term support needs of older people (65+) met by admission to residential and nursing care homes, per 100,000 population	334	369
Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	85.2%	85.2%

Overview narrative

Set out the overall plan for the area, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Non-elective admissions	Doncaster CCG and Doncaster Council have produced a Joint Commissioning Strategy for the period 2019-2021 which aims to prevent unnecessary hospital admissions by further developing Intermediate Care and the Rapid Response model. The BCF includes several schemes to reduce emergency admissions including: - RDaSH Unplanned Nursing (Emergency Community Nurses sent out by GPs to avoid hospital admissions). - Winter Warm (boiler prescription program offering high level community led interventions to reduce excess winter deaths, falls and hospital admissions) - Move More Doncaster (Supporting people aged 50+ to maintain an active & healthy lifestyle, increase bone health and reduce the number of falls)
Delayed Transfers of Care	Include your agreed plan for using the Winter Pressures Grant funding to support the local health and care system to manage demand pressures on the NHS, with particular reference to seasonal winter pressures. The Doncaster health and social care community has taken a system wide approach to managing Delayed Transfers of Care (DTOC), reducing Length of Stay (LOS) and implementing the High Impact Change Model (HICM). This reflects inter-relationships between the actions for each workstream. Improvements have already been made in both DTOCs and LOS; key priority enabling activities across these areas for 2019-20 are: • Early discharge planning, focus on choice and the discharge model in Doncaster • Further development of trusted assessment and trusted review • Enhancing housing pathways • Further focussed enhancements to 7 day services • Reviewing bariatric requirements With regards to specifically funded schemes that support DTOC in particular these include: - Intermediate care home first model - this is currently under development and is focussed on moving activity from a hospital bed based approach to a home based approach. This is expected to expedite discharges, working with the enhanced discharge model noted above - The End of Life domiciliary care model is proving to be particularly successful in Doncaster, with significant positive feedback from carers and relatives; this service is focussed on supporting timely discharge and maintaining people at home at the end of life The level of service commissioned has recently been reviewed and inceased, in light of demand. - A number of discharge to assess beds are in place across the Doncaster patch; these beds provide patients with more time to reach their potential in a more appropriate setting before being assessed for their longer term care needs. Whilst these beds prevent long hospital stays, pathways have also been refined to ensure that access to a discharge to assess beds is timely

	Other schemes: • Mental Health liaison schemes • Social Care pre-operative assessments • Unplanned Nursing • Integrated Discharge Team • Positive Step **Winter Pressures Funding** Allocation of the Winter Pressures Funding will enable the Council to continue to support the NHS by appropriately reducing both non-elective admissions and length of stay. This will improve outcomes for Doncaster people by increasing their health and wellbeing. It will also ensure continued capacity in social care services that otherwise would be at risk from continuing reductions in central government grant. Our winter pressures strategy includes: Rapid response to avert community crisis: • Increased capacity to ensure urgent community issues are dealt with quickly to reduce the potential for escalation and unplanned admissions to hospital or care home settings. A strong and consistent focus on "Home First": • enhancing availability of therapy support and assessment, minimising length of stay in hospital, supporting recovery and proportionate assessment in people's own home environment • improving the targeted capacity of the independent sector to provide rapid home care packages and additional provision especially in areas where historical supply has been challenging • sustaining overall independent sector capacity even in the advent of increased seasonal demand Ensuring capacity to escalate response when the system is under pressure: • Additional assessment capacity to enable flex • Capacity to invest in short-stay care home beds to supplement the Home First approach if necessary
Residential Admissions	The Joint Commissioning Strategy aims to further develop Intermediate Care to support independence in people's own homes and reduce admissions to care homes and also reduce the number people with dementia admitted to care homes. The BCF includes several schemes to reduce admissions to care homes including: -The Admiral service (case management and single point of access for people with dementia and their carers) -Community Led Support (care and support in community to help Doncaster residents maintain control of their own lives and maximise their independence, health and wellbeing) -Telecare Strategy (development of the Community Care Alarm Service and Telecare Equipment Services)
Reablement	The Joint Commissioning Strategy includes a target to increase in the percentage of people aged 65+ still at home 91 days after discharge from hospital into reablement/rehabilitation services The BCF includes several schemes to improve reablement including: - STEPS / OT service (6 weeks reablement programme to support people at home to avoid hospital admission). - Community Occupational Therapists Service (specialist community OT service eg moving and handling assessments, aids and adaptations) - Community Clinical Services Review (additional community based rehabilitation services)

Appendix 2

Better Care Fund 2019/20 Template

3. Summary

Selected Health and Wellbeing Board: Doncaster

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,451,971	£2,451,971	£0
Minimum CCG Contribution	£23,546,940	£23,547,000	-£60
iBCF	£14,320,932	£14,320,932	£0
Winter Pressures Grant	£1,509,880	£1,509,880	£0
Additional LA Contribution	£452,000	£452,000	£0
Additional CCG Contribution	£0	£0	£0
Total	£42,281,723	£42,281,783	-£60

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£6,691,373
Planned spend	£15,422,000

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£7,774,610	
Planned spend	£7,689,000	Planned spend is less than the minimum required spend

Scheme Types

Assistive Technologies and Equipment	£877,160
Care Act Implementation Related Duties	£57,000
Carers Services	£1,060,000
Community Based Schemes	£710,760
DFG Related Schemes	£2,451,971
Enablers for Integration	£5,167,932
HICM for Managing Transfer of Care	£1,900,770
Home Care or Domiciliary Care	£0
Housing Related Schemes	£673,000
Integrated Care Planning and Navigation	£1,472,000
Intermediate Care Services	£14,115,480
Personalised Budgeting and Commissioning	£2,163,000
Personalised Care at Home	£1,396,000
Prevention / Early Intervention	£1,328,830
Residential Placements	£895,000
Other	£450,000
Total	£34,718,903