City of Doncaster Council

Report

Date: 31/08/2023

To: The Doncaster Health and Wellbeing Board

Report Title: Better Care Fund Plan 2023-25

Relevant Cabinet Member(s)	Wards Affected	Key Decision?
Cllr Sarah Smith Cllr Rachael Blake	Boroughwide	No

1. EXECUTIVE SUMMARY

1.1 The Better Care Fund (BCF) plan and subsequent quarterly statutory return are the responsibility of the Health and Wellbeing Board. The BCF planning requirements and financial allocations for 2023-25 were issued by NHS England and NHS Improvement for return of submission on the 28th of June 2023.

1.2 The financial allocations for Doncaster are as follows:

Funding source	Income Year 1	Income Year 2
Disabled Facilities Grant	2,782,137	2,782,137
Minimum NHS Contribution	28,996,056	30,637,233
iBCF	16,310,384	16,310,384
Local Authority Discharge Funding	2,286,690	3,795,906
ICB Discharge Funding	1,711,000	2,774,000
Total	**54,112,550**	**56,299,660**

The minimum required to be spent from minimum ICB allocations is:

	Year 1	Year 2
NHS commissioned out of hospital spend from the minimum ICB allocation	8,239,857	8,706,233
Adult Social Care services spend from the minimum ICB allocations	9,573,771	10,115,647

1.3 The BCF national conditions and metrics have changed, these are:

- Avoidable admissions data (indirectly standardised rate of admissions per 100,000 population). The ambition is to have a phased improvement of 7% by quarter 4, factors supporting this improvement is the development of the virtual ward, the neighbourhood delivery model, focusing on community assets to improve health outcomes.

- Falls (emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000). The system wide frailty network is planned to deliver a 5% reduction in the standardised rate in 2023-24. A review of local pathways for falls with a focus on increasing activity, prevention, early identification, and intervention with support from the system wide frailty network.
- Discharge to usual place of residence (percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence). There is a quarterly improvement from baseline of 92.77% to 95% end of year 2023/24. We will work with existing health and care providers to deliver proactive care in the community for multi-morbid and frail individuals, we will fully implement hospital discharge policy and service specification.
- Residential admissions (long term support needs of older people aged 65 and over met by admission to residential and nursing care homes, per 100,000 population). The implementation of discharge to assess across all pathways this year will ensure that a timely review of pathway 2 admissions will support more people to return home in a timely way and positively impact upon transfers from short stay to permanent admissions to improve performance. The dementia diagnosis and treatment offer across Primary Care Networks (PCNs) to support in the development of best practice protocol.
- Reablement (Proportion of older people 65 and over who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services). Recognising data quality has been an issue in previous years, plans and actions are in place to improve reporting on reablement outcomes for people across all partners and commissioned services. Further develop the neighbourhood delivery model, enabling people within communities, together with organisations, to become equal co-commissioners and co-producers focussing on the holistic wellbeing, fitness and physical and mental health making the use of all assets to improve community outcomes.

1.4 Submission Timetable

The submission of Doncaster's BCF plan has been overseen by members of the Joint Commissioning Operational Group (JCOG).

BCF planning submission 2023-25	28th June
National assurance completed	28th July
Approval letters issued 2023-25	8th September
Quarterly reporting to resume	1st October 2023
Section 75 agreements to be signed off	31st October

1.5 Doncaster BCF Plan

Given that funding announcements were brought forward, the majority of existing schemes have been rolled over into 2023-25 with an uplift for inflation where appropriate. The final plan is required to be submitted to NHS England on a spreadsheet template with supporting narrative, however, for ease of review and comment, the key information has been extracted and attached as appendices:

Appendix 1: BCF narrative plan

Appendix 2: Financial summary detailing the budget plan for Doncaster Council and NHS South Yorkshire for BCF, iBCF and Disabled Facilities Grants.

2. EXEMPT REPORT

2.1 There are no exemptions or confidential information contained within this report.

3. RECOMMENDATIONS

3.1 That the board acknowledges sign-off of the BCF plan.
3.2 That the board notes a Section 75 agreement between South Yorkshire Integrated Care Board will be signed no later than 31st October 2023, that will include details of the new national conditions and metrics.
3.3 That the board reviews progress of Doncaster's BCF plan for 2023-25 and evaluation of BCF performance at future meetings.

4. WHAT DOES THIS MEAN FOR THE CITIZENS OF DONCASTER?

4.1 BCF plans address health inequalities and improved outcomes for vulnerable groups such as people experiencing homelessness, mental health challenges, learning disabilities and autism.
4.2 BCF is actioned jointly with a focus on working age and older adults.
4.3 BCF places emphasis on integrated working to improve outcomes for local people. Most notably improving discharge, reducing the pressure on urgent and emergency care and social care, supporting intermediate care, unpaid carers and housing adaptations.
4.4 Additional funded support is available to reduce delays in discharge, improve prevention, manage overall system flow and improve integration between health, housing and adult social care services.
4.5 Improved Better Care Fund (IBCF) is ringfenced to reduce seasonal pressures, support hospital discharge and sustainability of the social care market.
4.6 Disabled Facilities Grants (DFG) as part of BCF is ringfenced to enable housing authorities to continue to meet their statutory duty.
4.7 Adult Social Care Discharge Funding (ASC DF) as part of BCF is ringfenced to build additional social care and community based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvements for patients.

5. BACKGROUND

5.1 The BCF is a single pooled budget for health and social care services to work strategically 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 comprises a substantial level of funding in order to support health and social care integration.
5.2 BCF takes a strategic approach to integrated commissioning with reporting and planning jointly agreed by South Yorkshire Integrated Care Board (SY ICB) and City of Doncaster Council Chief Executive prior to sign off of plans from the HWB.
5.3 Broadly speaking BCF's aim is to make the most efficient and effective use of health and social care resources by breaking down organisational barriers. In doing so it assists people to live independently in their communities for as long as possible and to deliver the right care, in the right place, at the right time.

6. OPTIONS CONSIDERED

6.1 As national planning guidance and planning submission being brought forward, there is little alternative to continuing existing schemes between 2023-25.

7. REASONS FOR RECOMMENDED OPTION

7.1 There are limited timescales and notice periods required to end contracts.

8. IMPACT ON THE COUNCIL'S KEY OUTCOMES

Great 8 Priority	Positive Overall	Mix of Positive & Negative	Trade-offs to consider – Negative overall	Neutral or No implications
Tackling Climate Change	✓			
BCF provides fuel poor and vulnerable private sector owner occupied households with grant funding to repair/replace boilers and/or heating systems and other energy measures, including but not limited to boilers on prescription.				
Developing the skills to thrive in life and in work	✓			
BCF provides capacity and expertise to raise the profile of apprenticeships in health and social care, expand opportunities for apprenticeships into new vocational areas and ensure that apprenticeships form a core part of workforce planning and development arrangements going forward.				
Making Doncaster the best place to do business and create good jobs	✓			
BCF mitigated staffing capacity risks and market sustainability within adult social care by uplifting national living wage rates to support workforce retention through investment from the ASC DF.				
Building opportunities for healthier, happier and longer lives for all	✓			
BCF enables people to stay independent for longer and improves hospital discharge and reablement pathways through services across health, public health and adult social care.				
Creating safer, stronger, greener and cleaner	✓			

communities where everyone belongs				
BCF has recently commissioned a piece of engagement work which has informed the development of a Doncaster dementia strategy and future procurement of dementia services for pre and post diagnostic interventions and community therapies support service.				
Nurturing a child and family-friendly borough	✓			
BCF provides access to counselling for children under 12 that has reduced waiting times and improved the standard of counselling. The vulnerable adolescents project reduces the number of adolescents entering the care system through a therapeutic preventative approach. Doncaster's single 1001 days offer has improved antenatal and postnatal pathways around family hub services and childcare placements.				
Building Transport and digital connections fit for the future	✓			
BCF part funds the implementation of digital record sharing over five systems which include the DBTH clinical portal and RDASH System One. This will give Doncaster health and care professionals access to alerts, allergies, appointments, care plans, co morbidities, diagnoses, discharge information, encounters, medications, referrals and vaccinations.				
Promoting the borough and its cultural, sporting, and heritage opportunities				✓
Comments:				
Fair & Inclusive	✓			
BCF funds the stronger community wellbeing service that works with community adult learning disability teams and sensory teams. The Gypsy Roma Traveller (GRT) link workers provide workforce training in how to open communications with GRT groups and break down barriers with activities including health fayres, translation services, skills and training and further research into mental health/ suicide prevention.				

9. LEGAL IMPLICATIONS

Section 1 of the Localism Act 2011 provides the Council with a general power of competence, allowing the Council to do anything that individuals generally may do. Section 111 of the Local Government Act 1972 gives the Council the power to purchase goods and services. The Care Act 2014 places a number of duties to promote an individual's wellbeing, ensuring care and support provision is integrated together with other health provision.

Section 75 of the NHS Act 2006 allows partners (NHS bodies and Councils) to contribute to a common fund which can be used to commission health and social care related services.

10. FINANCIAL IMPLICATIONS HR 21/07/23

NHS England have confirmed allocations of funding that forms part of the Better Care Fund Plan for both 2023/24 and 2024/25. The table below shows the combined budgets allocated to Doncaster City Council and Doncaster Integrated Care Board (ICB) along with the previous year's underspend of Disabled Facilities Grant (DFG):

Funding source	**2023/24**	**2024/25**
Local Authority - Disabled Facilities Grant	2,782,137	2,782,137
Local Authority - Disabled Facilities Grant b/f	2,026,282	0
Local Authority - Minimum NHS Contribution (BCF)	9,521,000	10,058,000
ICB - Minimum NHS Contribution (BCF)	19,475,056	20,579,233
Local Authority - iBCF	16,310,384	16,310,384
Local Authority Discharge Funding	2,286,690	3,795,906
ICB Discharge Funding	1,711,000	2,774,000
Total	**54,112,550**	**56,299,660**

The conditions of the funding are set out in guidance provided by NHS England and a detailed plan has been submitted as per the deadline highlighted in para 1.4. Further conditions of the funding require sign off by the Health and Wellbeing Board and a Section 75 agreement between the Council and the ICB by 31st Oct 2023.

Quarterly monitoring reports are expected to resume for quarter 2 in 2023/24 whereby both expenditure and targets/progress against the metrics will be submitted to NHS England.

The Local Authority allocations formed part of the Council's Revenue Budget 2023/24 – 2025/26 and Capital Strategy and Capital Budget 2023/24 – 2026/27 agreed by full Council on 27th February 2023.

11. HUMAN RESOURCES IMPLICATIONS

There are no specific human resource implications in relation to this report.

12. TECHNOLOGY IMPLICATIONS

There are no specific technology implications in relation to this report.

13. RISKS AND ASSUMPTIONS

The risk of not completing the BCF plan 2023/25 is that regional and national assurance cannot be granted.

14. CONSULTATION

The annual return and narrative have been discussed at JCOG with initial feedback also being received from the regional Better Care Fund Manager.

15. BACKGROUND PAPERS

Not applicable

16. GLOSSARY OF ACRONYMS AND ABBREVIATIONS

BCF – Better Care Fund

SY ICB - South Yorkshire Integrated Care Board

HWB - Health and Wellbeing Board

IBCF - Improved Better Care Fund

DFG - Disabled Facilities Grants

ASC DF - Adult Social Care Discharge Funding

HICM - High Impact Change Model

DBTH – Doncaster Bassetlaw Teaching Hospital

RDaSH – Rotherham, Doncaster and South Humber

GRT - Gypsy Roma & Traveller

JCOG – Joint Commissioning Operational Group

17. REPORT AUTHOR & CONTRIBUTORS

Mike McBurney, Senior Policy Insight and Change Manager (Strategic Commissioning)
01302 736830; michael.mcburney@doncaster.gov.uk

Contributors: Joint Commissioning Operational Group representatives from commissioning and finance colleagues within Doncaster Council and South Yorkshire Integrated Care Board.

Lead Officer: Phil Holmes Director of Adults Health and Wellbeing

APPENDIX 1

Doncaster Better Care Fund Narrative Plan

2023 -25

1. BCF Governance

Better Care Fund (BCF) planning documents have received delegated sign off from Doncaster Health and Wellbeing Board (HWB). This follows consultation with officers across NHS South Yorkshire and relevant directorates within City of Doncaster Council such as Public Health and Adults Health and Wellbeing directorates, referred to throughout the BCF plan as the Local Authority (LA). It has been jointly developed with partners including NHS Trusts, social care, third sector organisations and the South Yorkshire Integrated Care Board (ICB). Established in July 2022, the ICB is responsible for planning and funding NHS services in South Yorkshire along with partner board members Healthwatch and Rotherham Doncaster and South Humber NHS Trust (RDaSH).

Doncaster HWB provides strategic assurance of BCF planning and reporting activities. There has been a number of stakeholders contributing towards the narrative plan, spending plans and BCF forecasted metrics. Plans have been informed by a refresh of our Doncaster Joint Strategic Needs Assessment and insights from what Doncaster communities have told us matters to them. It builds on all our existing strategies and plans and is aligned to the recently published South Yorkshire Integrated Care Partnership Strategy.

Stakeholders meet on a monthly basis at the Joint Commissioning Operational Group (JCOG) such as NHS South Yorkshire, Doncaster and Bassetlaw Teaching Hospital (DBTH), the LA and RDaSH. There are also contributions to the plan from stakeholders across Doncaster's voluntary community sector representatives, housing and Disabled Facilities Grant (DFG) leads.

2. Key Priorities

The key priorities for 2023-25 draws together the key workstreams and governance reporting across health, social care and public health life stage plans in order to understand the challenges, achievements and opportunities in Doncaster. This shapes how we collectively meet priorities and develop new ways of working across Doncaster as well as the services we commission and deliver. The BCF plan works across place, building on the foundations set out in the Place Plan, the Commissioning Strategy and the South Yorkshire Integrated Care Plan (ICP).

A key change since the previous BCF plan is the introduction of the One Doncaster Plan which replaces the Doncaster Place Plan as a long-standing strategic document that BCF schemes support. Community care and support networks are more prominent than ever in the plans to maximise independence and health and wellbeing with a priority around preventive approaches to improve outcomes and reduce health inequalities. There are 5 pillars within the One Doncaster Plan:

- Understand our communities: To strengthen community voices, using population health data to better understand health inequalities to focus action and resource allocation.

- Connecting people: To build on relationships, networks, and trust between partners and then to connect communities together.
- Access to services: To be inclusive, to make sure that no one is left behind with a focus on our Core20 and inclusion health communities.
- Shared approach: Commitment to the Doncaster shared care record supporting people to tell their story once.
- Model of delivery: To move towards a more needs-led, compassionate social model. Agree what to stop doing to create capacity for wider partnership working.

3. Overall BCF approach to integration

In Doncaster we have a joint Ageing Well delivery plan which identifies key areas within BCF, by working together as commissioners we will achieve the below commissioning vision:

"Doncaster ageing population will receive person centred flexible and integrated care and support in their own home that aims to maximise their health, wellness and independence"

We have robust joint commissioning arrangements across a number of services within Doncaster including but not limited to residential and nursing care and domiciliary care. This provides the market with clear direction and a seamless transition for people if they move from social care funding to health funding. It also provides the opportunity for joint market development and quality improvements. As part of the market sustainability fund, the LA and the ICB took steps to address the cost pressures within the market and utilised funding to increase care fees in line with the outcome of the fair cost of care, completed in 2022 and funded by the Adult Social Care Discharge Fund (ASC DF). These actions were in line with our joint ambition to increase capacity within the market and provide sustainable services within Doncaster.

Planning for BCF within Doncaster is completed jointly between the LA and the ICB. We have arrangements in place to discuss any proposals through the Joint Commissioning Operational Group (JCOG). Any proposals are considered across the partnership to ensure they deliver outcomes in line with our ambitions for Health and Social Care in Doncaster. The vision for Health and Care in Doncaster for 2023-25 has a clear ambition for all partners to prioritise prevention and have a population health management approach in order to impact on outcomes and reduce health inequalities:

"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 Doncaster Borough Strategy 2030 was launched in 2022 and describes the collective effort, through Team Doncaster, to improve the wellbeing of everyone in the borough. The Healthy and Compassionate quadrant within the Borough Strategy Team Doncaster partners include:

- NHS South Yorkshire Integrated Care Board
- Doncaster Metropolitan Borough Council
- Doncaster and Bassetlaw Teaching Hospital NHS Foundation Trust
- Rotherham, Doncaster and South Humber NHS Foundation Trust
- Primary Care Doncaster Limited

- Voluntary Action Doncaster
- Healthwatch Doncaster
- FCMS Ltd
- St Leger Homes Doncaster

Partners come together as members of the Doncaster Place partnership board which provides the formal leadership for Doncaster and is responsible for setting strategic direction and agreeing the broad objectives for Doncaster. It provides oversight for all Doncaster partnership business, and a forum to make decisions together on those matters which are best tackled collectively. There is a clear joint commitment of working together and a number of the key actions are also reflected across Doncaster place. The progress and impact of this joint working is monitored monthly by the Place Committee, who are able to unblock any areas that prevent this joint approach.

Both the dementia insight report and the findings of the survey have directly shaped the strategy priorities and specifications for both the pre and post diagnostic service and community therapy and support service, this will ensure that the commissioned service will deliver on the aims and vision of the strategy along with wider system/partnership working as the strategy won't be delivered by commissioned services alone.

4. BCF integrated case studies

a. *Dementia Service*

The dementia service is a partnership of 6 providers working together under an alliance agreement as a joint commissioning arrangement with commissioning leads from ICB and LA. This was commissioned jointly with providers RDaSH, Alzheimer's society, Making Space, Choices for Doncaster and Age UK. A recent engagement piece captured the voice of people living with dementia with the aim to improve their lives and inform future procurement of dementia services, namely pre/post diagnostic service and community therapies support service. This has highlighted areas of improvements to services and improve flow of information, support, navigating the system referral, assessment/ diagnosis and treatment process.

b. Frailty Project

It has been recommended that earlier identification of those at risk of falls/ deconditioning and improved coordination across system partners is needed. This includes using evidence-based interventions to help resident's rehabilitation and therefore lessen injuries due to falls. Improved access to preventative services, more efficient and consistent referral routes into reablement services will lead to increased professional knowledge of local services and place level services around frailty and new ways of working. The project is linking into appreciative inquiry work within Be Well Teams supporting 5 ways to wellbeing as part of health checks from GP surgeries. The project supports Primary Care Networks in early identification, multi-disciplinary approach, new way of working on a borough wide basis through social prescribing and a falls specialist contract. It is now standard practice to review tier 1 data in one place between DBTH and RDaSH (acute data) with South Yorkshire falls meeting taking place on a monthly basis with an overall blueprint for South Yorkshire. The frailty oversight group will develop and deliver a frailty action plan focussing on the following key areas:

- Early identification and prevention
- Multi-disciplinary team working
- Community voice

c. Vulnerable Adolescents

Child protection numbers are rising in Doncaster meaning a different way of working is needed with children and families by bringing a number of different service areas together. A new youth and adolescent board have been established with work undertaken with the teams to find a way for children to stay in their own home and target support with families.

The operating model is developed from individual therapeutic support plans as a flexible approach to create a sense of sustainability for young people in their family network with a focus on urgent intervention cases. The team takes a systemic whole family, trauma informed approach based on delivering individual therapeutic support plans developed through psychological formulation. Models of intervention include a number of different approaches such as relationship-based interventions to promote change, behavioural /parenting work, individual therapy adult or child with an attachment and trauma-based difficulties.

Vulnerable adolescents project has bespoke family intervention plans and outcomes framework which reviews the number of closures at 3-month, 6 month and 12-month intervals. Since becoming operational in April 2022, the team have worked with 61 families and 114 children and young people. Two young people have unfortunately entered the looked after children system, however, in 98% of cases intervention is currently enabling young people to remain living safely at home. This demonstrates the efficacy of the current approach, as the vast majority of children are diverted from the trajectory of becoming looked after and indicates the current model of practice is delivering sustainable change for young people.

5. National Condition 2 – Enabling people to stay well, safe and independent at home for longer through BCF schemes

Locality plans have been developed in conjunction with residents and set out what we will be doing to improve communities over the next two years. Partners engaged with communities through a number of different ways and the learning has been fed into individual locality plans. The themes identified by communities from engagement around health are listed below and feed into the Doncaster One Plan:

- Develop neighbourhood health services
- Improve communication and continually promote and improve personal wellbeing
- Continually promote positive health strategies and initiatives
- Raise awareness of and provide support to access local services and support
- More activities for the elderly, those isolated and lonely
- Increase awareness of being active and the benefits to mental health and wellbeing
- Promote and support access to apprenticeships and employment opportunities
- Raise awareness and publicise community mental health

Outcomes and impact on people:

- To take every opportunity to better support people in order to avoid crisis
- To support people to remain at home where possible
- To reduce the number of people waiting in hospital beds, who are fit to return home
- To support people to return to their usual place of residence
- To be able to care for people close to home to prevent people needing to be transferred away from Doncaster

The localities model takes an asset-based approach, with 100 community explorers supporting the top 30 areas of deprivation in Doncaster. Success stories include positive activity groups, access to green space such as a community led walking programme, embedding asset-based community development (ABCD) into amenities, access to the internet, clubs and groups. There has been a significant number of referrals in relation to weight management through health checks where 1: 1 support is provided for 6 weeks from the point of referral and peer groups have been established for long term conditions such as COPD, CVD and diabetes. Locality investment has extended over 55 community groups, participatory budgets have been launched supporting 140 groups and 4 host organisations for initiatives such as warm spaces. This is led by evidenced based community centred principles of local decision making, with citizens participating in deciding how public money is spent and encouraging greater opportunities for co-creating initiatives.

Locality development has 3 key elements:

- To empower and engage communities through Asset Based Community Development
- Integrated local delivery to provide a joined-up response and keep the person and family at the centre
- Commissioning and investment to give people more opportunity to shape communities

Short Term Enablement Programme (STEPS) contributes to non-elective admissions, reablement and discharge indicators. The features and benefits of the service includes a triage role and case management with an assessment period up to 6 weeks. The case manager reviews and tailors longer term support for locality teams and undertakes care act assessments to broker support such as referrals into the wellbeing team or financial assessments. The project has experienced a number of reforms such as Transfer of Care Hub, which has impacted how the team receive referrals. Improvements have been made to workforce sustainability to provide front line support staff by offering additional contracted hours, meaning there is less staff on rota, but more hours delivered. Quality assurance and reviews are being picked up in between direct care hours which is more proportionate due to post COVID step down procedures.

Workforce challenges are being addressed with allied health professionals being trained to provide low level movement and handling. Upskilling opportunities are being made available such as therapy training that allows people to be able to make decisions as a permissive culture. During COVID there was relaxed entry level qualifications and experience in care, these principles are continuing for people transitioning from other sectors such as food catering and hospitality. The team promote the benefits of working in health and social care through the Proud to Care campaign which also forms apart of mandatory induction programmes.

The transfer of care hub is bringing in partners from community health, therapy to make joint decisions about people's needs and pathways with cases of no right to reside in hospital reducing. We are following this up between 2023-25 by dealing with long term needs after discharge and introducing single handed care for therapists making better use of aids and adaptations. There are partner calls 3 times a week with any blockages or differences of opinion being dealt with at head of service level, attended by assistant director level and community nursing teams to help with proposing suggestions outside of the norm. For example, Positive STEPS service sometimes receive inappropriate referrals out of DBTH meaning reablement criteria needs to be changed to reflect pathway needs. There has been an increase in patient complexities which takes increased amount of time to assess/ discharge appropriately due to housing issues raised such as hoarding.

NHS health system Nerve Centre has now extended to staff, for example, information around ward beds to improve efficiencies and reduce duplication of tasks with accurate data for referrals and discharge pathways. Partners from community health, therapy are now making joint decisions about people's needs and pathways based on a describe not prescribe model with community support included in that discussion to assist in developing a positive risk-taking culture. The strategic enablers which will underpin all priority actions include:

Workforce: To analyse and understand system wide workforce priorities and to develop a Place wide workforce strategy. We are exploring 7 days working within the Integrated Discharge Team to offer continuity of staff with full knowledge of process and review current working arrangements such as length of time cases are held post discharge to support concentration on discharge to assess model and manage increasing demands on the team. There is a focussed effort in Doncaster to try to return people to their own homes for discharge dependent on availability of support and resources to do so. More support has been made to get people home in a timely manner by recruiting additional roles for people waiting for care packages in brokerage, for example specific timeslots for medication such as Parkinson's disease.

Estates: To make best use of our collective assets, to plan and deliver integrated services in the right places. Internal discharge co-ordination within the hospital trust has delayed discharge and frequent issues with availability of transport and medications being ready has impacted significantly on the number of discharges achieved. Discharge lounge is to be open earlier to support discharges before 10am and maximise use of transport throughout the day. Further work will be undertaken in 2024 to develop discharge to assess and reducing complex assessments taking place in the acute settings. Senior Managers from all partners are to discuss new ways of working and sign up to increasing community support for assessment post discharge.

Finance: There is a shared commitment to work together at place level to make the most effective use of our resources, enhancing productivity and value for money. BCF funded scheme Sheffield City Church Council are working proactively to support people following hospital discharge with some great examples of innovative working and we are already starting to see improvements with pathway 0 and pathway 1 with more timely discharges, reduced bed delays, strengths-based approach and improved integrated relationships. It has been reported due to the cost-of-living crisis, people are returning items rather than keeping them despite the benefits and safeguards they bring.

Digital: Digital services will empower Doncaster people to maximise their own health and wellbeing and enable our teams to deliver high quality integrated care. IT solutions are accessible for health and social care staff to share information and access up to date timely progress from other professions to reduce volume of phone calls to wards, saving time and informing plans and assessments. Further investment in telecare and pendants will remove the need for a formal care package such as community district nursing or occupational therapists. Yorkshire Ambulance Service refer low level triage/ heart responders which makes a difference to the cost to the Ambulance Service, allowing them to deal with life critical events. The service is currently going through a restructure with dedicated responders and installers currently undertaking a dual role with further management structure, recovery and improvement report completed and awaiting approval to commence. There is a new call centre system trialling telecare equipment, working with the hospital falls GPS pendant and tracking app. This requires patients to have mental capacity and has certain obstacles to overcome such as personal data infringements. This new intervention will reduce costs, get people home quicker, remove the need for multiple aids such as bed senses starting with 100 units which should enable swifter discharge without waiting for installation of lifeline units. Intelligence in the service has improved with a detailed approach to collecting reablement data with referrals being taken from Doncaster and Bassetlaw Teaching Hospital, STEPS, Tickhill Hospital, Mexborough Hospital, Barnsley Hospital and self-referrals.

6. Capacity and Demand for intermediate care to support people in the community

A clear strategy and implementation plan for whole system discharge planning has been signed off to improve the alignment to home first principles and best practice. Home First review demand and capacity for each discharge pathway, including the overall skills and workforce needed to meet those demands now, and in the future. The plan is to maximise pathway 1 discharges, access to recuperative care at home services, and improve integration of the transfer of care hub and single point of contact. There will be a review around the current rehabilitative care at home service, to include therapy resource and utilisation and system oversight of discharge ready date. As a system we will develop internal professional standards for discharge, with clear timescales for all partners to ensure improved oversight arrangements are in place, including admitted care home residents and better utilisation of EDD as a driver for discharge.

There will be defined roles and responsibilities of the site team and divisional teams in patient flow management, including proactive capacity planning across 7 days. This will help further develop appropriate patient flow policies and procedures, including escalation and full capacity protocol. Understanding the daily capacity requirements for all services will support forward planning of capacity to manage forecast demand. Work is in progress to develop real time core datasets, displayed in all appropriate areas to support the management of effective manage patient flow. There will be a suite of reports to enable the system to understand capacity and demand, including constraints, to support effective planning and oversight across each of the key workstreams to provide assurance for agreed system wide improvement plans.

There is a clear strategy and implementation plan for Urgent and Emergency Care (UEC) model following a whole system process mapping exercise and UEC redesign to determine how patients should enter the system, ensuring right clinical first team. This will assist the other workstreams to design their service to meet the demand including a workforce review

to develop internal professional standards that reflect the whole trust, to include a review of access and response times for diagnostics utilising 7 day standards.

A revised operating model for the frailty pathway from the request for urgent and emergency care to patient returning to their home and establish a frailty assessment model, to include same day emergency care. This will include redefining inpatient ward processes to ensure all patients have clear plans including criteria for discharge through effective and consistent board rounds. Length of stay reviews will be undertaken twice weekly over 7, 14 & 21 days. There will be a development of a process to ensure all delays and appropriate actions are taken to reduce delays and review of the discharge lounge to understand the lack of utilisation and to develop a revised operating model with a roll out of virtual wards across all wards.

Emergency Care Improvement Support Team led a system review for Doncaster in January 2023 where they made recommendations around the key priority areas of focus. There was a commitment to Doncaster Concordat, signed by all system partners and a commitment from senior responsible owners and project management support from across the system with the urgent and emergency care improvement programme board to be established with monthly reporting to the A&E delivery board. Work is progressing to develop appropriate patient flow policies and procedures, including escalation and full capacity protocol. Understand the daily capacity requirements for all services to support forward planning of capacity to manage forecast demand (including weekend planning).

7. Provide the right care in the right place at the right time

A significant focus of our use of BCF funding has been to improve market shaping and commissioning of adult social care and support, helping providers with recruitment and retention to ensure sustainable care capacity and prevent market failure. We have also maintained a strong focus on preventing, reducing and delaying needs through investment in a range of intermediate care services that are designed both to pre-empt crisis (and avoid admission) and to enable recovery (and avoid re-admission).

The High Impact Change Model (HICM) is a critical element of our home first community model. Bed based services contribute to the overall success of our shared outcomes framework for the intermediate care service. There is an agreed approach to implementing the BCF Policy objectives, including a capacity and demand plan for intermediate care services. This ensures that people are supported to maintain their independence and live at home, preventing admissions to acute care and supported to return home as early as possible. It reduces the number of people requiring long term care and support more people to remain at home following an episode of intermediate care. When intermediate care is needed people receive a simple, responsive and flexible service resulting in improvements to their functioning and quality of life.

HICM has significant implications for social care practice such as focused activity on the early discharge planning and trusted assessors which supports our care and health systems to manage patient flow and discharge. This includes planning in advance for residents who require elective care to ensure timely discharge and to ensure that support is in place in the community. There still remains capacity issues in embedding trusted assessors within the care home and home care sectors and community single point of access. However, we recognise this is crucial to enable early engagement with patients, families and carers so that they can consider their options for future care and discharge.

Since previous assessments against the HICM, more data on capacity and demand is available and distributed across the system to help manage pressures daily. An improved list of patients requiring support after discharge is being shared across partners to allow daily review and support to help move patients through the system and reduce blockages. The actions agreed and associated with the HICM are all linked to the Home First Board, this has resulted in the development of the transfer of care hub, and we are now looking at redesigning pathways to ensure that we have adequate patient capacity and that we reduce duplication and highlight areas of opportunity as we head into the winter months. This will involve better linkage with housing services, housing teams, acute hospital housing pathways and mental health, processes including a regular review.

Daily system surveillance is coordinated by the ICB through a system escalation report. This report is based on operational pressures which triggers escalation thresholds against a framework linked to capacity and demand across Doncaster health and social care. Daily dashboard reports are issued widely across Doncaster partners to alert capacity issues, promote escalation discussions and gain partner support.

As a system Doncaster responds to capacity and demand through system flow monitoring meetings that are now starting to include some further pathway 0 data for the first time, which are reported to the chief operating officers regularly. In addition, weekly system partner calls are held with operational managers to discuss current state and support required with further escalation calls added as need be.

Interdependencies exist between BCF funded projects such as the home first strategic change manager as data sharing and access to records are essential as are interdependencies with urgent and emergency care programme of work. BCF funded neighbourhood frailty project manager has interrogated Integrated Care Board data that has led to further data requests from the Yorkshire Ambulance Service to try and understand what is happening in the system. For example, overall numbers have been reducing but treat on scenes has increased.

There could be strategic improvements with early intervention and crisis response management being more proactive with better acknowledgement of the third sector plays in reducing demand with more efficient and consistent referral routes into reablement services. This is why in part BCF funded project Inclusion and Fairness forum was incorporated into the Voluntary Action Doncaster business case. This project aims to increase resident's choice in community services and contribute to agendas such as loneliness, social isolation and the reduction of non-elective hospital admissions, these are representative of the three life stages, starting well, living well and ageing well. They also provide strategic representation across seven strategic meetings in Doncaster:

- Safer Stronger Doncaster
- Children's and Families Strategic Partnership Board
- Enterprising Doncaster
- Health and Wellbeing Board
- Joint Commissioning Management Board
- Doncaster Integrated Care Partnership Board
- Team Doncaster

BCF funded system flow work will expand and be more resilient over the winter period. We will aim to include more prediction of estimated discharges where data allows to support

planning by services ahead of time as well as expanding current acute system flow analysis to mental health. Through BCF funded ISAT Wellbeing Officers we are able to develop sustainable partnership data sharing across the system by having a shared set of data asks and requirements. For example, improved quality of life, increased independence, reduction in social isolation, reduction in secondary care attendance and reduction in unnecessary admission into long term care.

A shared understanding of the discharge to assess pathways will be in place by end of October 2022. Predictive model and mental health flows are to be developed over the coming months and some basic analysis in place for use this winter. The monitoring work will never be complete as there are degrees of data maturity we should be seeking to build across the system. We know when we will be successful through system stakeholders holding one version of the truth on capacity and demand information and more crucially sharing the same insights. The end outcome is to develop a system that is more able to proactively manage capacity and demand across the system, with fewer escalation issues.

8. BCF funding to ensure duties of the care act are being delivered

Discharge funding is being used to support a very significant fee increase across homecare, care home, extra care housing and supported living provision. This increase (26% for homecare provision) fully addresses the cost of care identified by the recent DHSC exercise. This will better ensure that care capacity is there to support onward discharge, particularly increasing flow along pathway one of the discharges to assess model.

We're working across all partners to improve the end-to-end experience that Doncaster people have, from the first moment they need support from Urgent or Emergency Care to the point where they are back to living the life that they choose. This involves planning for discharge from the point of admission, ensuring a strong and consistent focus in NHS wards, bolstering a single point of access to enable transfers of care to community health and social care services, and maximising the capacity of those services both through increased investment and greater efficiency. Partners have informally agreed with formal sign off will take place at Doncaster's Urgent and Emergency Care Board on 7th July 2023.

All partners are continuously reviewing how the greatest impact can be achieved in terms of reducing delayed discharges through urgent and emergency care board and home first board. This includes how Doncaster will utilise discharge funding in regard to wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients. The use of the additional discharge grant is in line with grant conditions with the fund being used to continue schemes started in 22/23 that is now categorised as existing in 23/24.

There are various funding streams which support Doncaster's winter plan with the ASC Discharge Fund element of BCF making up over a third of Doncaster's winter plans contribution, it is therefore difficult to say specifically what the discharge fund alone supports as funding streams have been pooled together based around whole system flow. The plan was signed off by urgent emergency care board in March and was agreed by system partners.

Stretching metrics have been agreed locally for all BCF metrics based on current performance, local priorities, expected demand and capacity and planned BCF funded services and changes to locally delivered services based on performance to date. Plans include the expansion of virtual wards and at the same time reviewing pathways out of

Yorkshire Ambulance Service and expanding provision to meet that demand, through the expansion of urgent community response.

Review of the bed base and funding of existing intermediate care will enable us to build on better forecasting demand to meet winter pressures. There is further investment into a BCF funded discharge coordinator role to expand the size of the discharge lounge, which will improve flow in line with meeting key performance indicators. This will meet occupancy targets, reduce the average number of daily beds occupied and increase capacity to deflect patients into same day health centre additional appointments. Equally the BCF funded carers lead will provide strategic oversight of initiatives for unpaid carers and create efficiencies for health and social care teams.

Doncaster carried out a local cost of care exercises to provide that understanding of inflationary pressures and was undertaken in consultation with providers. The care home market has seen additional monies provided by BCF to support workforce recruitment and retention, National Living Wage and increasing cost pressures.

We will be publishing our Market Position Statement (MPS) in the Autumn of 2023 with an annual refresh. This will provide an overview of the current services operating across Doncaster, as well as providing key indicators to the market in terms of what the future needs and demands are for Doncaster. The MPS will be publicised to ensure that it reaches a wide audience to encourage new providers into the city, as well as to stimulate interest and further enhance the market provision across all services.

On a bi-monthly basis meetings are held with care homeowners and Senior Management from both City of Doncaster Council and South Yorkshire ICB (SYICB). Additional specialist meetings are also arranged at the care homeowner's request. On a quarterly basis meetings are held with care home registered managers and operational commissioning team, workforce development and other health and social care professionals to support and provide pertinent information and advice about any new work streams or changes in guidance and procedures across Adult Social Care and Health.

9. Supporting unpaid carers through BCF

Doncaster carers wellbeing service is the main source of support for unpaid family carers in Doncaster and they complete all carer assessments. We recognise the significant and vital contribution carers make in our communities, and we value the support they offer to the person they care for, which often prevents, reduces and delays the need for more formal services. We also know that being a carer can be tough at times, so we want to make sure carers have the support they need to look after their own health and wellbeing, and to continue in their caring role for as long as they are willing and able to do so. This is why BCF supports personalised carer support through the carer's innovation fund which aims to remove barriers and waiting times for support to enable carers to continue within their caring role and to do the things that matter most to them. The service provides more in-depth support with the service serving carers face to face, within groups, online or over the telephone.

Doncaster's All Age Carers Strategy, 2022- 2025 'we hear, we listen, we care, if you care' has been co-produced with Doncaster carers, to improve the experience of caring in Doncaster. Carers are key members of the team around the person they support, but the role can significantly impact their own life, health and wellbeing. A carers action group has been established for carers to have their say and be listened to as experts by experience.

This enables carers to have the choice to be involved in all workshops and other engagement opportunities and have a safe place to talk and be signposted to relevant services. A strategy has been developed and led by people with lived experience and reflects the national and local priorities.

Engagement and feedback were gathered through online semi structured interviews with carers, online questionnaires, focus groups and in depth follow up interviews. This involved the carers strategic lead and carer representatives attending meetings, having group discussions as well as in-depth conversations with carers about their experiences. Carers from all types of caring circumstances were involved to ensure a holistic view, this included carers from ethnic minority carers, young carers, older carers, carers for those with mental illness, carers for those with dementia and further carers with a range of protected backgrounds.

Some of the challenges in accessing evidence are carers often do not see themselves as a carer; many carers report that it takes a long time for them to recognise and accept being a Carer. Carers are often not identified as carers when engaging with health and social care support this means that professionals do not have an understanding of their caring role, the challenges that can come with caring and how best to support carers. Whilst some schools identify and work with young carers there continues to be a number of schools which do not readily recognise or support young carers. Health, social care, and housing services do not identify carers and as a result, do not support them to maintain their wellbeing.

Improvements have been made in service the carers wellbeing service provides bespoke carer support rather than the traditional offer to carers that was not consistently well connected with assets within localities. The implementation of the carer's wellbeing service has evidenced a need for additional BCF funding to support carers within adult learning disabilities teams. There are 147 carers who are in the main aged 80 + years of age, quality conversations and sensitive support relating to future planning is needed with this cohort of carers. Many of these carers do not use IT and require a more bespoke service such as home visits.

10. Disabled Facilities Grant

Disabled Facilities Grants (DFG) promotes integration between occupational therapy and housing. For 2022/23, Doncaster's housing adaptations policy has been amended to permit discretionary grant funding if works exceed £30k subject to sufficient funds being made available to meet this demand. This is prudent with supply and installation costs increasing in recent years and the complexity of needs for disabled applicants, particularly children. In addition, there has been changes to assist with relocation and funding of equipment or adaptations that fall outside the mandatory grant criteria.

We have adapted our service so that our technical officers spend the majority of their time processing DFG, upon receipt, these are allocated to our officers usually within a week with urgent referrals prioritised. During COVID 19 we altered our way of progressing DFG completing most of the application form via the phone, so the time spent at service users' home is minimal in terms of collecting proof of financial information and obtaining signatures. This has helped speed up the process, which is vital to help keep people safe and independent in their homes and has prevented hospital and care homes admissions. Carrying out essential adaptations has reduced reliance on social care system and improves the quality of life of not only the disabled person but their spouses, carers and family alike.

Any complex referrals for adaptations are visited with equipment provided promptly to help those in most need to live independently for longer and improve quality of life for the disabled person and their families. If work schedules are overwhelmed, then approved contractors are used however this is often not needed as staffing capacity are at sufficient levels. The majority of referrals from housing associations are coded and work issued without a visit needing to take place. For instance, if a referral with pictures of the bathroom is received for a bath to be replaced with a level access shower, the service can raise an order using our schedule of rates and submit to our contractor upon receipt of an asbestos report.

Trying to facilitate hospital discharges can at times be problematic, therefore, a multi-agency response was set up to look at how we could improve the process where we jointly develop the hospital discharge pathway protocol, with regular meetings held with the NHS foundation Trust. One of the strategy action plan themes are homes being more accessible and inclusive in their design, able to meet residents' current and future housing needs. This includes implementation of the recommendations of an accessible housing service review covering the accessible housing register and aids and adaptations.

The aids and adaptation team and strategic housing team have worked closely together for many years. This has enabled the inclusion of specific properties or specification requirements into the Councils own new build, housing association, and acquisition programmes, which has delivered a number of properties to meet the needs of people and families with disabilities across the borough.

Hospital discharges minor works are continuing to provide an efficient and effective service for Doncaster's most vulnerable populations. By working in an integrated way with Public Builders Management (PBM) it has helped to speed up processes such as sending digital images of homes for urgent orders.

The housing adaptations team take referrals from health professionals with allocated spend based on recommendations from occupational therapists across health and social care. The project has increased business support within the housing adaptations team, to accelerate the processing of referrals received for adaptations for disabled and older persons and assist in the overall delivery of adaptations.

There are more telephone assessments rather than home visits, meaning referrals are being received quicker leading to longer waiting lists. External contractors have exclusively been utilised in extensions with PBM delivering all other adaptations. However, external contractors are now picking up level access showers which has reduced waiting times from 3 months to 28 days, helping to alleviate the backlog alongside extending the PBM team from 9 teams to 12 teams.

The Regulatory Reform (Housing Assistance) Order 2002 permits Local Authorities the power to adopt a policy to apply a much-simplified system, such as waiving means testing for a specified amount. This venture will fast track appropriate adaptations, reducing delays and enabling those requiring essential adaptations to regain their independence faster.

The rationale behind the figure of £5,000 is that the related administrative process of means testing can cost more than the value of a grant for smaller works and result in a significant slowing of the delivery process. Along with the above statement, the figure of £5,000 is also used, as above this, costs are registered as a local land charge and there is a requirement to repay monies if the property is sold within ten years. Adaptations and equipment that are

provided in a timely manner, help those in most need to live independently for longer, and improve quality of life for a disabled person and their families. Adaptations can reduce hospital admissions and reduce the amount of care provision required and provide a long-term saving for both LA and the ICB. Consequently, the quicker adaptations are delivered, the sooner those receiving will benefit however, supporting evidence has to be provided of all bank accounts. The evidence needs to be up to date and often it is not, resulting in officers making several journeys in an attempt to get the correct and up to date information required. The cost of journey time travelling, and mileage incurred would also have to be taken into account, resulting in delays getting approval for the proposed works. Removal of the test of resources will result in an ongoing loss of income, however this needs to be balanced with the reduction in activity needed to administer. The reduction in activity will free up the officers to carry out further additional surveys and other activities and of greater importance is the reduction in the time a person has to wait for a visit to be carried out to start the process. Considering the time taken to administer this as a process it is therefore recommended that this means test is ceased for all proposed works that have a value of less than £5000. This £5000 limit will capture the vast majority of DFGs provided and will significantly speed up the time taken to process DFG applications for the benefit of customer. The most common adaptations are altering bathrooms into wet rooms, installing stairlifts or ramping entrances. Where these works cost less than £5,000, the proposal is that the disabled person is subject to a fast-track application, without the need for a means test, resulting in a person receiving essential adaptations sooner.

11. BCF initiatives that supports equality and address health inequalities

There is extensive evidence that connected and empowered communities are healthier communities. Communities that are involved in decision-making about their area and the services within it, that are well networked and supportive and where neighbours look out for each other, all have a positive impact on people's health and wellbeing. There is a diverse range of community interventions, models and methods which can be used to improve health and wellbeing or address the social determinants of health. Below are the key elements of community centred approaches:

- Recognise and seek to mobilise assets within communities. These include the skills knowledge and time of individuals, and the resources of community organisations and groups
- Focus on promoting health and wellbeing in community settings, rather than service settings using non-clinical methods
- Promote equity in health and healthcare by working in partnership with individuals and groups that face barriers to good health
- Seek to increase people's control over their health and lives
- Use participatory methods to facilitate the active involvement of members of the public

Community centred approaches involve building on community capacities to act together on health and the social determinants of health. It includes community development, asset-based approaches, social action, and social networks. These approaches work by connecting people to community resources, practical help, group activities and volunteering opportunities to meet health needs and increase social participation. Embedding community centred approaches in how we work with communities' challenges traditional ideas of health improvement by working with communities to shape more effective health care and welfare services. Focusing on improving health and wealth and ensuring all residents have the

opportunity to be part of vibrant, connected communities, and living in pleasant environments, rather than a deficit-model of tackling specific health issues in isolation.

Participatory budgeting is a form of citizen participation in which citizens are involved in the process of deciding how public money is spent. Local people are often given a role in the scrutiny and monitoring of the process following the allocation of budgets. Evidence has shown that even on a smaller scale, participatory budgets have contributed to improving the self-confidence of individuals and organisations, improving intergenerational understanding, encouraging greater local involvement through increased volunteering and the formation of new groups, increasing confidence in local service providers, and increasing control for residents over the allocation of resources. The locality investment community grant provides an opportunity for smaller, less-resourced community groups in Doncaster to make a difference. The process provides an easily accessible and alternative method compared to the traditional written application. Applicants are required to complete an application of their choice (video/verbal/presentation/ written application). Applicants will be asked to submit a full cost breakdown with anonymised applications reviewed and scored by a locality community-led panel.

41.3% of the Doncaster population live in the most deprived 20% of communities nationally. Healthy life expectancy for women living in deprived areas of Doncaster is the third worst in England at 56 years. This means that women living in deprived communities will live 24 years and men 21 years in poor health, resulting in poor outcomes for people, which impacts on them individually and their families and also drives significant demand for health and care services. 1 in 3 children are living in fuel, bed and food poverty, impacting on their early childhood development and future health and wellbeing as adults. In response BCF has funded health inequalities lead role to work with health and care, communities themselves, Team Doncaster and third sector partners and there is a clear commitment from the Doncaster Place Committee and from the Health and Wellbeing Board to thread health inequalities through all that we do.

DBTH and RDaSH have had board workshops, focusing on health inequalities and what it means for their trusts and core business. They have also invested in a joint consultant in Public Health, who is also linked into the Public Health Team in Doncaster Council. This post will support analysis of waiting list data and support both trusts to apply a population health management approach to operational delivery of planned and unplanned care. This will facilitate a better understanding of who is on waiting lists in terms of areas of deprivation and ethnicity and also who is using emergency pathways. Reviewing the way that they work with their patients, recognising the importance of better understanding the challenges that people from Core20 communities and inclusion health groups face, when it comes to accessing and experiencing services. There is a commitment to embedding coproduction and including people with lived experience in service development and delivery.

Each of the Primary Care Networks (PCNs) have a designated health inequalities lead. The place inequalities lead is working with each PCN to develop their action plans and support them to be more focused on Core20 populations and inclusion health groups (e.g., people experiencing homelessness and rough sleeping, Gypsy Roma Traveller (GRT), sex workers, asylum seekers, prison leavers and people affected by addiction). Funding has been secured to support PCNs and localities to develop plans which focus on developing more personalised care for patients, particularly Core20 and inclusion health groups. The north locality held a workshop in March 2023, which included a wide range of partners, such as PCNs, secondary care, community services, locality teams, Team Doncaster, third sector

partners, maternity, family hubs, Healthwatch and many more. The aim was to build connections and increase awareness of all of the services available in the community, which could support the health and wellbeing of people accessing primary care and perhaps reduce pressure on primary care. An action plan will be co-produced with the wider community partners, it is proposed that the locality workshops will be rolled out across east, south and central localities. Health inequalities lead is attending all GP target training sessions in June 23 to increase awareness of health inequalities and gather enthusiasm and support from PCNs for the workshops which will run in September.

Taking time to listen to the challenges our Core20 and inclusion health communities have when it comes to accessing healthcare has been and will continue to be an important element of the work to tackle health inequalities. It takes time to build trust and understanding, especially when some communities are fatigued with people and services coming out to ask them the same questions. Feedback is that they answer the questions, but never hear from people again and also that nothing happens. We are committed to being held to account for listening and for coming back with updates on what can and cannot be done. Key challenges to accessing services include transport, lack of buses, no money for buses, caring responsibilities, literacy, language and interpretation, lack of flexibility, inability to navigate healthcare pathways, cultural sensitivities, digital and social isolation.

There is definitely no one size fits all, so it is important we take the time to work with wider groups, often through trusted community leaders. There are plans to work more closely with the third sector over the next 12-months. Relationships are building with Healthy her Muslim Ladies, People Focused Group (including people with mental health disorders, learning disability and autism, GRT and complex lives (people experiencing homelessness and rough sleeping).

Two GRT community link workers have been funded by BCF until April 2024. GRT communities experience significant marginalisation and hate crime, resulting in social exclusion and lack of access and good experience of healthcare. It is proposed to work with PCNs and healthcare organisations to improve awareness of GRT culture and in turn improve access and experience of healthcare. There are plans to focus on Core20 plus5, including maternity and early cancer diagnosis, access to primary care, elective care, workforce and children and young people, activities include:

- Health fairs
- Translation
- Reviewing available data
- Education skills and training
- Deeper dive into mental health/ suicide prevention in GRT communities

Much of the GRT link workers early work involved partnering on health initiatives which target underrepresented groups which had obvious synergies for this project. For example, collaborating with the cancer alliance based in Sheffield meant there was an increase of GRT patients taking up cervical screenings. This work was championed by Dr David Crichton who has lived experience of working with members from the GRT community.

The relationships and connections made between partners and with communities are embedded and there is recognition that good awareness and trust with communities is essential to success. This team now focus on wider Core20plus5 programme, which does include flu, covid and pneumonia vaccinations but also includes maternity continuity of care,

annual health checks for people with severe mental illness, early cancer diagnosis and blood pressure case finding and lipid management. Development is underway to create a Doncaster focused training video to support increasing awareness of health inequalities. Cross partner forum to coordinate community engagement across Doncaster is set up, focusing on Core20 and inclusion health groups. Forum members include Health Watch, DBTH, RDaSH, Adult Social Care, PCNs, Team Doncaster and Voluntary Action Doncaster. The group will build on excellent work of Team Doncaster, supporting development of a standard Doncaster approach to gathering intelligence from communities, which will inform service development and delivery.

There is much work to do to support health and care staff to be aware of the levels of poverty in Doncaster and to understand the impact this has on the ability for people to navigate health and care. Equally further developing and raising awareness of 'Your Life Doncaster' will be key for staff and residents as a self-serve community online directory. Developing a compassionate approach and embracing the 'Be Kind' campaign are an important element of building trust and relationships with our communities' who find our services to reach and will require a partnership approach.

There is a need to build relationships, trust and connections across health and care, including residents and patients. This started by increasing awareness of the services and support available to people with the aim to reduce demand in health and care and improve outcomes. We have increased awareness around health inequalities and impact of poverty, Core20 populations and inclusion health groups with an importance placed on partnership working and integration. We reach out to communities' who find our services hard to reach or access.

Doncaster is striving to better understand the tough lives that many people are living and why they find our services hard to reach e.g., transport, translation, digital and social exclusion. We need better understanding of different communities, Core20 and inclusion health groups and their unique cultures and challenges created with digital models of care and virtual consultations. We will ensure that health inequality is a key part of all transformation priorities and that all partners prioritise prevention and a population health approach to improve outcomes and reduce health inequalities.

We have set up an inclusive cancer screening network to develop culturally appropriate videos for Core20, ethnic minority and inclusion health groups, it is hoped that once the connections are made, we can roll out Core20plus5. NHSE have supported a cervical screening pilot in principle taking screening to trans men, Afghan refugees and women accessing complex lives and changing lives services. The Core 20 plus 5 population groups experiencing poorer than average health access, includes Doncaster residents with conditions including, cancer, respiratory disease and cardiovascular disease. By using the health profiles to generate insights (population health management approach), the Doncaster priorities are around the clinical areas of health inequalities, such as:

- Maternity
- Severe mental illness
- Chronic respiratory disease
- Early cancer diagnosis
- Hypertension case finding
- Smoking cessation

BCF funded project Be Well Doncaster has been working with community organisations and set up community-based peer groups for wellbeing, fibromyalgia, diabetes and chronic obstructive pulmonary disease (COPD) across each locality and an online hidden conditions peer group. The peer groups provide education, information, and an opportunity for peer support to enable better self-management. A range of communication and marketing material including videos and flyers have been developed to launch the text self-referral service. This allows residents to text a free number to request to meet with a coach. It is hoped this approach will raise the profile of Be Well Doncaster across partners and with residents to increase referrals from outside the PCNs, widening the reach of Be Well Doncaster. Well Doncaster team have continued to support the third sector using community centred approaches and offering support in accessing funding, public health guidance updates and building community resilience as groups continue to make a return to their communities. We will develop a culture of improvement and collaboration which is inclusive of our people, and which drives the delivery of timely access to high quality and safe care. This work will improve access, reduce assessments and ensure interventions are readily available.

- Enhance the understanding of health inequalities in Doncaster.
- Establish links with existing groups and partners to standardise approaches to address health inequalities and promote inclusion in accessing and receiving health care.
- Demonstrate progress against nationally and locally defined Health Inequality targets and objectives, including Core 20 plus 5 by working with existing teams and partnerships.
- Use the opportunities available through Anchor Institutions to enhance the health and wellbeing of Doncaster people, particularly where there is opportunity to narrow health inequalities and address the wider determinants of health and wellbeing.

Health inequalities has been raised as an important public health intervention which was highlighted through community insights such as Joint Strategic Needs Assessment, our borough wide listening exercise Doncaster Talks and appreciative inquiries. These have helped to inform the local priorities related to health inequality and equality for people with protected characteristics within integrated health and social care services. Respondents emphasised the need for Doncaster to be Disability Friendly and more community cohesion, with a small number of comments praising the co-ordination of health and support services but that more can be done for vulnerable cohorts (to help homelessness, addiction and mental health). This theme encompassed responses that the public felt were missing from a health point of view with a large number of people highlighting the need for more social care, particularly funding for and access to care services.

Addressing inequalities enables local communities to do more and promote inclusion, equality and diversity that, in turn, will improve the health of individuals. Be Well Team, Wellbeing Officers and Healthier Doncaster are examples of BCF funded programmes to support strategic collaboration between local areas, public health and educational institutions. The high-level aims are to:

- Reduce inequalities, improving the health of the poorest fastest
- Increase resilience at individual, household and community levels
- Reduce rates of worklessness, a cause and consequence of poor health

The Healthier Doncaster programme seeks to tackle the underlying causes of ill health through behaviour change techniques such as motivational interviewing, coaching and brief intervention. Both programmes utilise resources from link workers who co-ordinate with local priorities having particular regard to the needs of Black, Minority Ethnic groups.

We look to commission projects and programmes of work that support an increase in healthy life expectancy and a reduction of the number of mortality rates in under 75's. Consideration needs to be given to the impact of the pandemic on health and social care, where instances of burnout are reported, and primary care services are really stretched. We are seeing elective waiting lists backlogged and workforce shortages meaning attention to health inequalities is sometimes secondary to meeting our service offers.

Building community capacity and support is therefore important to Doncaster's response with locality teams engaging community leaders across grass root organisations, social enterprises and charitable organisations in how we can best provide solutions to multifaceted, socio economic, challenges. Locality teams fund a variety of posts through BCF including voluntary community social enterprise pharmacy teams, care coordinators, community connectors, health and wellbeing coaches and social prescribers.

Doncaster has strong leadership and commitment to partnership working to improvement of health and wellbeing of underserved communities, where we create an environment where they have a freedom to innovate health and social care offers. For example, BCF funded project Complex Lives which provides mental health support across housing especially for those in transitions and complex rehabilitation and recovery pathways as part of the homelessness and rough sleeping strategy. The delivery plans include prevention, accommodation and care and support, to convene of a range of multi-agency forums to drive forward delivery.

Team Doncaster continues to work in partnership across health and social care to further develop services, so everyone has the opportunity to age well, have a good quality of life and to be able to live as long and as independently as possible. Older people have told us that they feel that they have aged, lost some independence and have reduced ability to do things that they enjoy doing. The ongoing vision for Doncaster residents is that they will receive their health and social care in a cohesive, integrated, coordinated way, eliminating inefficiency and waste by providing a model that supports people remaining safely at home, wherever possible, with an increase in strength based preventative activity.

Doncaster have developed an evidenced base outcomes framework to shape and drive our work in reducing health inequalities and build stronger, more resilient communities linked to our wellbeing goals. By focusing on community centred approaches at an individual, community and organisational level, we have the best chance of closing the health gaps that have only widened since the COVID-19 Pandemic. BCF funded projects help to bridge the gap between existing health inequalities and improve resident's healthy life expectancy.

APPENDIX 2

Financial Summary 2023-25

Source of Funding	Scheme Type	Expenditure 23/24 (£)	Expenditure 24/25 (£)
Additional LA Contribution	DFG Related Schemes	2,026,282	0
DFG	DFG Related Schemes	2,782,137	2,782,137
iBCF	Enablers for Integration	1,262,800	1,262,800
	Home Care or Domiciliary Care	1,573,200	1,573,200
	Integrated Care Planning and Navigation	770,812	770,812
	Personalised Budgeting and Commissioning	5,728,572	5,728,572
	Residential Placements	6,975,000	6,975,000
ICB Discharge Funding	Urgent Community Response	1,711,000	2,774,000
Local Authority Discharge Funding	Home Care or Domiciliary Care	726,000	74,390
	Workforce recruitment and retention	1,560,690	1,560,690
Minimum NHS Contribution	Assistive Technologies and Equipment	1,021,000	1,074,000
	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	7,060,000	7,477,000
	Carers Services	1,093,000	1,150,000
	Community Based Schemes	1,268,000	1,331,000
	Enablers for Integration	109,000	115,000
	High Impact Change Model for Managing Transfer of Care	2,163,000	2,290,000
	Home-based intermediate care services	2,645,000	2,836,000
	Housing Related Schemes	130,000	93,000
	Integrated Care Planning and Navigation	1,236,000	1,306,000
	Personalised Care at Home	1,861,000	1,966,000
	Prevention / Early Intervention	1,679,000	1,769,000
	Urgent Community Response	8,731,056	9,230,233
Total		**53,460,939**	**54,138,834**
Local Authority Discharge Funding	To be allocated subject to review of 2023/24 schemes		2,160,826
Grand Total		**54,112,549**	**56,299,660**