

**Executive Summary Better Care Fund Plan 2023-25**

**1. BCF Governance**

Doncaster HWB provides strategic assurance of BCF planning and reporting activities. 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.

**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 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.

**3. Overall BCF approach to integration**

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 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 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”*

**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. 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.

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

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.

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 several reforms such as Transfer of Care Hub, which has impacted how the team receive referrals. 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.

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 effectively 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. 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 remain 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.

**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.

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.

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.

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 understand 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 several 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.

**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 most 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. Most 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.

**11. BCF initiatives that supports equality and address health inequalities**

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 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.

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 such as 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.

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.

1. **Financial Summary 2023-25**

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| --- | --- | --- |
| **Source of Funding** | **Scheme Type** | **Expenditure 23/24 (£)** |
| **Additional LA Contribution** | DFG Related Schemes | 2,026,282 |
| **DFG** | DFG Related Schemes | 3,024,769 |
| **iBCF** | Enablers for Integration | 1,262,800 |
|  | Home Care or Domiciliary Care | 1,573,200 |
|  | Integrated Care Planning and Navigation | 770,812 |
|  | Personalised Budgeting and Commissioning | 5,728,572 |
|  | Residential Placements | 6,975,000 |
| **ICB Discharge Funding** | Urgent Community Response | 1,711,000 |
| **Minimum NHS Contribution** | Programme Management | 103,000 |
| **(CDC)** | Carers Lead | 56,000 |
|  | Hospital Based Social Workers | 245,000 |
|  | Homecare Management | 33,000 |
|  | HEART/Telecare | 968,000 |
|  | STEPS/OT service | 2,155,000 |
|  | RAPT | 123,000 |
|  | Positive Steps Social Care Assessment Unit | 2,416,000 |
|  | Hospital/Discharge Worker | 30,000 |
|  | SPOC/One Point | 66,000 |
|  | Well North | 208,000 |
|  | Affordable Warmth | 87,000 |
|  | Healthier Doncaster | 305,000 |
|  | Integrated Discharge Team | 240,000 |
|  | Occupational Therapist | 352,000 |
|  | Community Wellbeing Officers | 446,000 |
|  | Community Care Officers | 83,000 |
|  | Mental Health Social Work | 223,000 |
|  | Community Adult Learning Disability Team | 69,000 |
|  | Complex Lives | 50,000 |
|  | Amber Project | 134,000 |
|  | Doncaster Mind | 200,000 |
|  | Dementia Support | 167,000 |
|  | Home from Hospital | 72,000 |
|  | Carers Innovation | 70,000 |
|  | Social Care Funding | 620,000 |
| **Local Authority Discharge Funding** | Home Care or Domiciliary Care | 726,000 |
|  | Workforce recruitment and retention | 1,560,690 |
| **Minimum NHS Contribution** | Intermediate Care (Bed Based - Rapid / Crisis Response) | 3,056,000 |
| **(ICB)** | Intermediate Care (Bed Based - Step Up/Down) | 4,242,000 |
|  | Mental Health Liaison and Treatment | 1,140,000 |
|  | Intermediate care | 5,676,000 |
|  | Dementia Alliance | 801,000 |
|  | Carers Breaks | 964,000 |
|  | Stroke Early Supported Discharge | 535,000 |
|  | End of Life Domiciliary care | 1,861,000 |
|  | Discharge to Assess - Beds | 0 |
|  | Virtual Ward | 1,200,000 |
| **Total** | | **54,355,125** |