Name and brief description of proposal / policy / service being assessed Better Care Fund

The Better Care Fund (BCF) (previously referred to as the Integration Transformation Fund) was announced in June as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change. The Health & Well-being Board will be responsible for determining utilisation of the Fund

The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work Clinical Commissioning Groups (CCGs) and Councils are already doing. It should be noted that only 5% of the funding available through the BCF is new funding – the remainder is an pooling of existing funding streams including:

- Section 256 funding transfer from Health to Social Care
- Reablement Funding
- Carers Breaks Funding
- Disabled Facilities Grant
- Social Care Capital Funding
- Transfer from Acute Health budget

7% of the BCF budget will be performance related and released on attainment of aspirational targets against the following metric:

Non elective hospital admissions

The additive elements of the Nottingham BCF plan amounts 18% of the total funding available and will be utilised to develop the following:

- Care Coordination Service to support the Care Deliver Groups
- Expansion of Health and Care Point
- Support 7 Day working across primary care
- Development of the Tele-health programme
- Mental Health In-reach Discharge Coordinators

Information used to analyse the effects on equality

A variety of qualitative and quantitative data has been used to inform this EIA. This includes:

- Statutory Health and Social Care data returns
- JSNA in relation to older people and those with long-term conditions.
- Integrated Adult Care engagement events with Health and Social Care professionals
- Specific engagement with Patient Participation mechanisms and recipients of social care services

	Could particularly benefit (X)	May adversely impact (X)	How different groups could be affected: Summary of impacts	Details of actions to reduce negative or increase positive impact (or why action not possible)
People from different ethnic			The objective of the Integrated Adult Care programme is	Performance against BCF performance
groups			to streamline and integrate Health and Social Care service	objectives will be monitored across Health

Appendix 3 Equality Impact Men, women (including	7.000001110110		delivery mo		
maternity/pregnancy impact),					
transgender people			development		
Disabled people or carers	X		benefit to al		
People from different faith groups			older people		
Lesbian, gay or bisexual people			responsive to		
Older or younger people	X		on early		
Other – please specify			independenc		
			Citizens cont an integrated they are mo function to r crisis) and in		
			The care of streamlined long-term co complete act focus on directore care coordinate. Navigate needs act and care. Monitor streaml. Complete referrals. Gather in intervent.		

delivery models and systems, positively transforming citizen experience of how their needs are met. The development of an integrated care pathway will be of benefit to all those with long-term conditions (including older people with complex needs) will be based on, and responsive to, the aspirations of the citizen and predicated on early intervention, prevention, maximising independence and optimising citizen choice and control.

Citizens contacting Health and Care Point will benefit from an integrated and expanded service. This will mean that they are more likely to be routed to the appropriate function to meet their needs (enablement, reablement, crisis) and in a shorter timeframe.

The care coordination service will result in a more streamlined service for the frail elderly and those with long-term conditions. The aim of a care coordinator is to complete administration tasks to release clinicians to focus on direct patient contact and support. The role of the care coordinator will be to:-

- Navigate and coordinate services to meet individual's needs across the CDG.
- Act as a point of contact for professionals, citizens and carers.
- Monitor service capacity to assist the CDG to manage demand
- Complete relevant referral documentation and chase referrals as required.
- Gather information to support assessment and intervention.
- · Order and follow up equipment orders.

All citizens will benefit from 7 day access to primary care services. BCF funding is concerned with ensuring that there are routes into community health and social care provision and assessment over the weekend. This will in turn facilitate discharge from hospital.

People with a long-term condition will benefit from the rollout of tele-health. By 2018 200 patients will be able to have their vital signs monitored remotely in a home rather than hospital environment. This will facilitate prevention and enable nurses to focus resources on those with

and Social Care and reported to the Health & Well-being Board on a bi-annual basis and to the Health & Well-being Board Commissioning Executive Group on a quarterly basis. A particular focus of this will be the value of the additive elements in meeting overall BCF and Integrated Adult Care objectives

An evaluation framewrok has been commissioned as part of the Integrated Adult Care programme. A key focus of evaluation will be qualitative data from citizens and health and social care professionals as to the ongoing benefits accrued as a result of the programme. Regular evaluation reports will be provided. to the Integrated Adult Care Programme Board and modifications will be made to the programme as approipriate.

Appendix 3 Equality Impact Assessment Form						
	critical care needs					
	The expansion of the Mental Health In-reach Discharge service will benefit those with acute mental health needs by reducing the amount of time taken to facilitate discharge from a hospital to community setting					
Outcome(s) of equality impact assessment:						
	Adverse impact but continue Stop and remove the po	olicy/proposal 🔝				
Arrangements for future monitoring of equality impact of this proposal / policy / service:						
Health and Well-being Board Commissioning Executive Group – quarterly monitoring reports						
Approved by (manager signature):	Date sent to equality	Date sent to equality team for publishing: Send document or link to				
Antony Dixon – Strategic Commissioning Manager		ualityanddiversityteam@nottinghamcity.gov.uk				