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Nottingham City Council

Nottingham City Health and Wellbeing Board Commissioning Sub-Committee

Date: Wednesday, 27 September 2023

Time: 3.30 pm or at the rising of the Nottingham City Health and Wellbeing Board if that is later

Place: Ground Floor Committee Room, Loxley House, Station Street, Nottingham, NG2 3NG

Governance Officer: Phil Wye, Governance Officer **Direct Dial:** 0115 8764637

The Nottingham City Health and Wellbeing Board's Commissioning Sub-Committee is a partnership body whose role includes providing advice and guidance to the Board in relation to strategic priorities, joint commissioning and commissioned spend; performance management of the Board's commissioning plan; and taking strategic funding decisions relating to the Better Care Fund.

Agenda		Pages
1	**Apologies for Absence**	
2	**Declarations of Interests**	
3	**Minutes** To confirm the minutes of the meeting held on 26 July 2023	3 - 6
4	**Better Care Fund 2023 - 2025 - Better Care Fund Planning Requirements - Retrospective Approval**	7 - 68

Councillors, co-optees, colleagues and other participants must declare all disclosable pecuniary and other interests relating to any items of business to be discussed at the meeting. If you need any advice on declaring an interest in an item on the agenda, please contact the Governance Officer shown above before the day of the meeting, if possible.

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Nottingham City Council

Nottingham City Health and Wellbeing Board Commissioning Sub-Committee

Minutes of the meeting held at Loxley House, Nottingham on 26 July 2023 from 3.37 pm - 4.15 pm

Voting Membership

Present	Absent
Sarah Fleming (Chair)	Dr Dave Briggs (sent substitute)
Katy Ball	
Mohammad Shaiyan Rahman (substitute)	
Councillor Linda Woodings	

Non-Voting Membership

Present	Absent
Lucy Hubber	Ailsa Barr
Sara Storey	Sarah Collis

Colleagues, partners and others in attendance:

Catherine Cameron-Jones	-	Commissioning Manager, Nottingham City Council
Katy Dunne	-	Nottingham and Nottinghamshire Integrated Care Board
Richard Groves	-	Head of Access and Prevention, Nottingham City Council
Phil Wye	-	Governance Officer, Nottingham City Council

23 Apologies for Absence

Ailsa Barr
Dr Dave Briggs
Sarah Collis

24 Declarations of Interests

None.

25 Minutes

The Committee confirmed the minutes of the meeting held on the 29th March 2023 as a correct record and they were signed by the Chair.

26 Occupational Therapy and Adaptations business case

Richard Groves, Head of Access and Prevention, presented the report on capitalisation of the Disabled facilities grant (DFG) to secure funding of £449,895 in order to create additional posts in Occupational Therapy, equivalent to the current proportion of work undertaken on adaptations by Occupational Therapists supporting use of the DFG.

This funding will be used to increase the number of full time equivalent (FTE) posts within Occupational Therapy for the creation of a Principal Occupational Therapist, a Team Manager, 4 Occupational Therapists, and 3.5 Occupational Therapy Advisors.

Usage of the DFG in this way does reduce the amount available for adaptations, however there is a regular underspend on this and a full business case has been conducted to demonstrate feasibility.

Resolved to endorse the decision to capitalise on the Disabled Facilities Grant to increase Occupational Therapy capacity prior to Portfolio Holder decision.

Reasons for decision:

- The waiting list for Occupational Therapy Assessment is currently at 690 adults and 45 children with an average waiting time of 6 months and 555 citizens having had to wait over 28 days for an assessment.
- The resource requested is based upon the number of staff/equivalent cost per locum or per assessment it will take to reduce the waiting list and hold it within acceptable tolerances (less than 28 days).
- The waiting list is equivalent to 393 citizens waiting for an assessment for Adaptations. The number of unallocated pieces of work continues to be a concern with most referrals into the service waiting over 28 days. This impacts on the experience of citizens as well as the risk of deterioration during the waiting period.

Other options considered:

- Do nothing - capacity continues to outweigh demand with considerable pressure on the existing Management structure to deliver from within limited confines. Occupational Therapy is a key preventative measure and a failure to meet further demand will create additional pressure on Social work team as well as financial burden on the council.
- Create an Interim capacity to reduce the waiting list - there is every likelihood that once the interim facility came to its natural end then demand for the service would increase. An interim facility only goes as far as to address the short term solution and does not create the foresight needed to safeguard the council's future financial position through preventative action. There is also no guarantee that we would be able to recruit to temporary positions and the continued use of agencies remains questionable in light of the current financial climate. This solution also does not address issues around accountability amongst appropriate numbers of Managers within the team.

27 Better Care Fund 22-23 Year-end Template Report

Katy Dunne presented the report on the Nottingham City Better Care Fund 2022 - 23 Year-end reporting template that was submitted to NHS England & Improvement on 23rd May 2023.

The following system challenges in meeting the metric targets for 2022-23 have been highlighted:

- Urgent Community Response service is operational but has been challenging to ensure all GPs and healthcare professionals are aware of it across the ICS, despite full geographic coverage being in place.
- Challenges around night time provision for Pathway 1 services – we will be working with system partners to pilot short term night time provision during 2023/24 and the learning will inform longer term Pathway 1 transformation.
- Figures indicate a result of 687.5 admissions per 100,000 population. This is 77.5 people, over the target of 610 people. The average number of new admissions each month has increased this year.
- Figures for the proportion of older people still at home 91 days after discharge indicate a result of 78.1% against a target of 80%. A further 10.2% of citizens could not be traced (47), some of whom may still be at home.

Resolved to approve the 2022-23 Better Care Fund Year-end template

28 Future Meeting Dates

Resolved to meet on the following dates:

- **Wednesday 27 September 2023 at 1:30pm**
- **Wednesday 29 November 2023 at 1:30pm**
- **Wednesday 24 January 2024 at 1:30pm**
- **Wednesday 27 March 2024 at 1:30pm**

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Nottingham City Health and Wellbeing Board
Commissioning Sub-Committee
27 September 2023

Report Title:	Better Care Fund 2023 - 2025 Better Care Fund Planning Requirements - retrospective approval
Lead Officer(s) / Board Member(s):	Katy Ball – Director of Commissioning, Nottingham City Council Sarah Fleming - Programme Director for System Development, NHS Nottingham and Nottinghamshire Integrated Care Board
Report author and contact details:	Katy Dunne, Senior System Development Manager, NHS Nottingham and Nottinghamshire Integrated Care Board katy.dunne@nhs.net
Other colleagues who have provided input:	
Subject to call-in: ☐ Yes ☒ No The decision cannot be subject to call-in because it is for retrospective approval	
Key Decision: ☒ Yes ☐ No	
Criteria for a Key Decision: **(a)** ☐ Expenditure ☐ Income ☐ Savings of £750,000 or more, taking account of the overall impact of the decision **and/or** **(b)** Significant impact on communities living or working in two or more wards in the City ☐ Yes ☐ No	
Type of expenditure: ☐ Revenue ☐ Capital	
Total value of the decision:	£107, 201, 731

Executive Summary:

1. The purpose of this paper is to ratify the Nottingham City 2023 – 25 Better Care Fund planning requirements, which were submitted to NHS England on 28 June 2023.

2. The paper provides a brief update to the Health and Wellbeing Board Sub-Committee on the BCF Root and Branch Review and proposed next steps.

Information

3. The Better Care Fund (BCF) Planning requirements 2022 - 25 were released on 4 April 2023. Following sign-off by Katy Ball (Director of Commissioning and Procurement, Nottingham City Council) and Amanda Sullivan (Accountable Officer, Nottingham and Nottinghamshire Integrated Care Board), the Better Care Fund 2022/23 Planning Template, BCF Narrative Plan and BCF Capacity and Demand Templates were submitted to NHS England on 28 June 2023.

4. For 2023-25, the BCF planning requirements include:
   i. Nottingham City BCF Planning template (Appendix 1)
   ii. Nottingham and Nottinghamshire BCF Narrative Plan (Appendix 2)

5. The BCF National Conditions remain in place for 2023 - 25:
   a) A jointly agreed plan from local health and social care commissioners signed off by the Health and Wellbeing Board
   b) Implementation of the BCF objectives
   c) NHS contribution to adult social care to be maintained in line with the uplift to ICB minimum contribution at a value of £29,089,765 for year 1 (2023/24) and £30,736,246 for year 2 (2024/25)
   d) Invest in NHS commissioned out of hospital services meets the minimum contribution required of £8,266,486 for year 1 and £8,734,369 for year 2

6. This is the first time that systems have been asked to produce a two-year BCF plan. The 2023-25 national BCF objectives remain the same as the previous year and maintain the focus on addressing wider system and prevention outcomes through co-ordination of services. The 2023 - 25 BCF national objectives are:
   i. Enable people to stay well, safe, and independent at home for longer
   ii. Provide the right care in the right place at the right time

7. **The 2023 -25 BCF Planning Template** includes the updated national performance metrics with target setting rationale and plans to meet performance ambitions (Appendix 1 tab 7). The 2023-25 national BCF metrics are:

   a. **Avoidable admissions:** Indirectly standardized rate of admissions per 100,000 population
   b. **Falls:** Emergency hospital admissions due to falls in people aged 65 and over directly age standardized rate per 100,000.
   c. **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.
   d. **Residential admissions:** Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population.
   e. **Reablement:** Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.

8. Commissioners from Nottingham City Council and the ICB jointly reviewed the target setting for BCF metrics. These are required for year 1 (2023/24) only and will be refreshed at year end. The rationale for target setting used national benchmarking and applied local improvement plans such as implementation of the anticipatory care model framework and the system agreement to continue to prioritise funding to resource 'pathway 1' reablement activity. A local Integrated Care System (ICS) BCF performance dashboard has been created to enable shared oversight of progress to reach targets.

9. The BCF Planning template (Appendix 1, tab 6a) provides detailed breakdown of expenditure against service areas. This includes spending for the two years covered by the plan (2023/24 and 2024/25). This includes the schemes which are funded through the Additional Discharge Funding specifically to support discharge from hospital. This funding was introduced mid-year in 2022-23 to support alleviating winter pressures and is now embedded as part of the BCF.

10. **The Nottingham and Nottinghamshire BCF Narrative Plan** (Appendix 2) describes how these services are commissioned and delivered to meet these objectives. The BCF narrative provides the ICS overview of the BCF plan, including how BCF programme align to our system priorities, transformation programmes and our

approach to integration and how this is underpinned by the ICS Collaborative Planning and Commissioning Framework.

11. The narrative plan demonstrates that the BCF is a key component of the ICS Integrated Care Strategy and how it supports delivery of the ICS vision. The narrative plan themes our BCF plans and services across three priority areas:

    a) **Prevention and early intervention services:** e.g., integration of lifestyle reaching health inclusion services with health and care pathways;
    b) **Proactive Care** e.g., integration of MDT case management and development of PCN Neighbourhood teams, outcome and impact monitoring and our ability to plan demand and capacity for admission avoidance;
    c) **Discharge to assess services:** integration of housing support, adaptation and temporary accommodation, ability to meet complexity of need at home (Pathway 1).

12. The Health and Wellbeing Board Sub-Committee is now asked to formally approve the submitted planning templates and narrative plan in line with the statutory Better Care Fund governance requirements.

Local BCF Review

13. A collective strategic review of the existing BCF plans was undertaken by the ICB and Local Authorities between May and August 2022. The review has been undertaken in three phases which are detailed below:
    - Phase 1: shared clarity, understanding and forward plan for BCF between ICB and Local Authorities
    - Phase 2: analysis of existing BCF scope under three key themes; prevention, proactive care and discharge to assess to identify opportunities for integration
    - Phase 3: stakeholder workshops to agree approach to deliver the collaborative opportunities identified

14. The findings and recommendations of phases 1 and 2 of the BCF review have now concluded and will be reviewed by Nottingham City HWB in November 2023. Phase 3 is now in train and the ICB, County Council and City Council are continuing to collaborate to take forwards the recommendations of the review and finalise the priority areas for further integration, with leadership provided by the Collaborative Commissioning Oversight Group. This will be progressed with considerable stakeholder engagement across Health and Wellbeing Board members, commissioning and provider organisations and Place Based Partnerships. This will be galvanised through two workshops to take place during October and November 2023.

Does this report contain any information that is exempt from publication?
No

Recommendation(s):
The Committee is asked to approve the 2023 – 2025 Better Care Fund Planning Requirements

The Joint Health and Wellbeing Strategy	
Aims and Priorities	**How the recommendation(s) contribute to meeting the Aims and Priorities:**

Aim 1: To increase healthy life expectancy in Nottingham through addressing the wider determinants of health and enabling people to make healthy decisions **Aim 2:** To reduce health inequalities by having a proportionately greater focus where change is most needed **Priority 1:** Smoking and Tobacco Control **Priority 2:** Eating and Moving for Good Health **Priority 3:** Severe Multiple Disadvantage **Priority 4:** Financial Wellbeing	The priorities for 2023 - 25 build on our progress to date and reflecting system transformation priorities. The BCF continues to support a joined-up approach to integration across health, care, housing and other agencies such as the voluntary sector to support people to live independently at home. The BCF funding has been used to deliver a wide range of services and new functionality that support integrated approaches e.g. integrated care teams, sharing data across organisational boundaries, integrated approaches to hospital discharge. The development of our Collaborative Commissioning and Planning Framework have underpinned the view that the BCF will become a key driver for transformation and integration. During 2023/24 we will build on the recommendations of the 'root and branch' commissioning review of the services and contracts that form our BCF plans. This will consider how future BCF plans and approaches to commissioning can better enable Place Based Partnerships and Neighbourhoods to develop and deliver community-facing integrated care, joining up community services across sectors and working with community leaders.

How mental health and wellbeing is being championed in line with the Board's aspiration to give equal value to mental and physical health:

The schemes and services that form the Better Care Fund plan include care coordination and multi-disciplinary health and care planning. This should include meeting mental health needs as part of proactive care pathways and hospital discharge planning.

This has been strengthened by the maturing Place Based Partnership (PBP) in its ability to build further integration and joined up system working and delivery of holistic health and care.

Reasons for the decision

a. The report template was agreed for submission to NHSE by the following, subject to formal ratification at the Nottingham City Health and Wellbeing Board on the 28 June 2023.
b. Subsequently, the Nottingham City Health and Wellbeing Board Sub-Committee is asked to formally ratify the templates. The Nottingham City 2023 - 25 Better Care Fund planning template submission is shown in full at **Appendix 1.**

Other options considered and rejected

None – submission is a requirement

Risk implications
Not applicable

Financial implications
There are minimal financial changes as result of the plan, schemes and commissioning are largely continuation of the previous years.

Procurement implications
Not applicable

Equalities implications
Equality Impact Assessments are completed by the appropriate commissioning organisation as part of the implementation of new services or significant changes to existing services. The 2023 - 25 BCF Narrative Plan (Appendix 2) includes further information about the approach to equality and addressing health inequalities.

Any further implications
Not applicable

List of background papers relied upon in writing this report (not including published documents or confidential or exempt information)
PRN00315-better-care-fund-planning-requirements-2023-25.pdf (england.nhs.uk)

Published documents referred to in this report
PRN00315-better-care-fund-planning-requirements-2023-25.pdf (england.nhs.uk)

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2023 - 2025 Better Care Fund Narrative Plan

Nottingham City HWB
Nottinghamshire County HWB

v1.0 28/06/2023

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Contents

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Section 1

Our ICS approach

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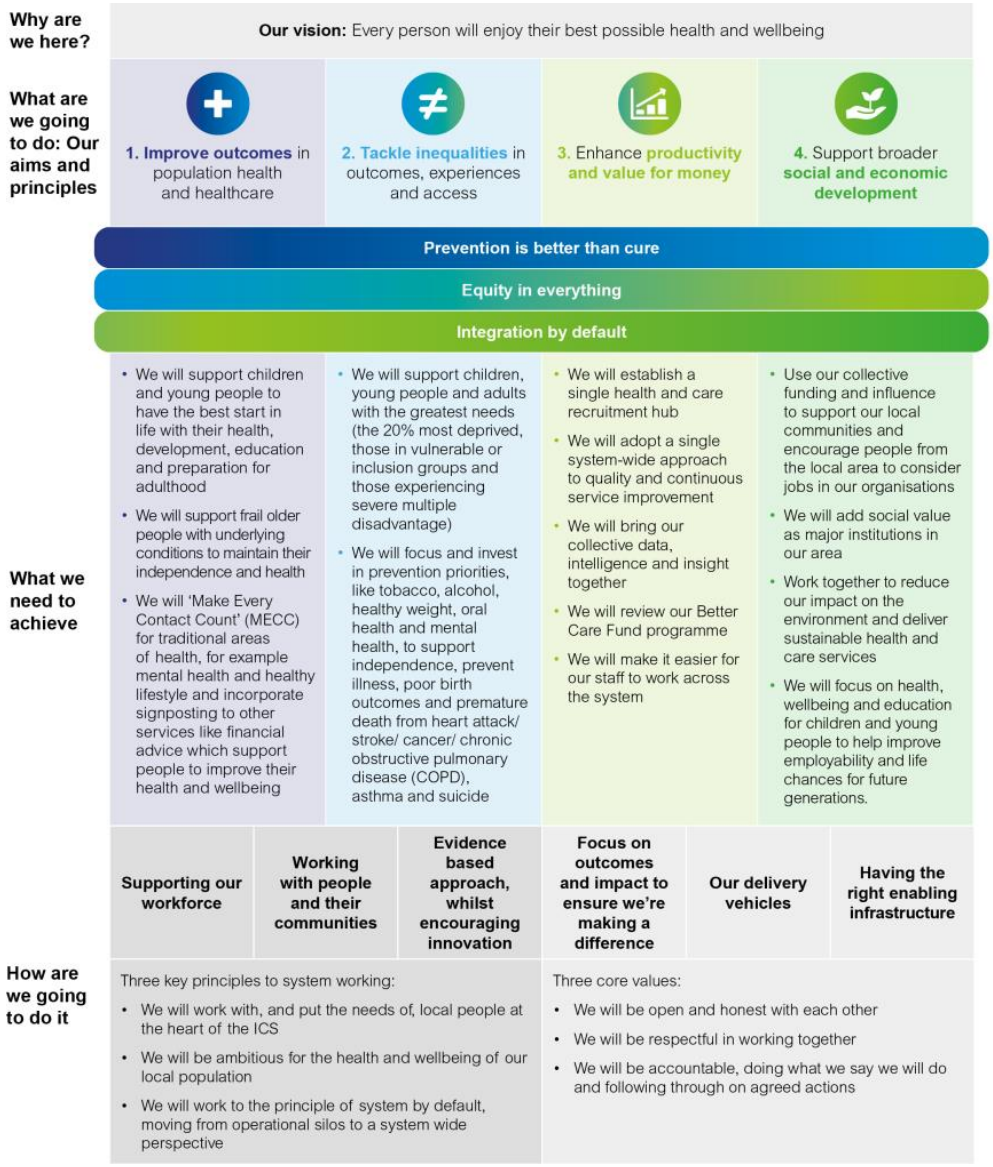
Our Integrated Care Strategy was agreed by the system in March 2023, and sets out our strategic aims for 2023-28.

1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience and access
3. Enhance productivity and value for money
4. Support broader social and economic development

The Strategy is based on three guiding principles:

1. Prevention is better than cure
2. Equity in everything
3. Integration by default

The BCF is a key component of our strategy and we will continue with our review to enhance collaborative commissioning of BCF schemes.



How the 2023 -25 BCF supports delivery of our ICS Vision

ICS Vision

Our neighbourhoods, places and system will seamlessly integrate to provide joined up care. Every citizen will enjoy their best possible health and wellbeing

BCF objective

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Priority work areas

- **Ageing Well** Anticipatory Care Model
- **Living Well** Prevention, maximising independence and 'early help'
- **Urgent Care** Discharge to Assess and Transfer of Care Hubs

Enabling System programmes

- **Community Transformation**
- **System development**
- **Data insight and interoperability**

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Aim of the Better Care Fund

The Better Care Fund (BCF) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care .

The ICS is committed to drive collaboration, innovation and integration through the BCF plans.

There are two joint plans: one agreed by Nottingham and Nottinghamshire Integrated Care Board (ICB) and Nottingham City Council; and one agreed by Nottingham and Nottinghamshire Integrated Care Board (ICB) and Nottinghamshire County Council. The plans are owned by the Health and Wellbeing Boards (HWBs) and governed by an agreement under section 75 of the NHS Act (2006).

The national conditions for the BCF 2023 -25 are:

- Jointly agreed plan between local health and social care signed off by the health and wellbeing board.
- NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution
- Invest in NHS commissioned out-of-hospital services
- Implementing the BCF policy objectives:
    - Enable people to stay well, safe and independent at home for longer
    - Provide the right care in the right place at the right time.

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Our Collaborative Planning and Commissioning Framework

VISION

To deliver **Integrated Health and Care** within the ICS, joining up strategic leadership and the transformation of health and care to improve outcomes for our population, ensuring decision making is led and integrated at the appropriate population level, with an emphasis on subsidiarity.

PRINCIPLES

Why we are taking this approach

- We will deliver improved outcomes and reduce health inequalities, driven by an understanding of the needs of our population
- We will optimise the use of our collective resource by reducing duplication, moving away from services commissioned and delivered in silos, making it easier for people to access the right support or care to meet their needs
- We will enable providers to work collaboratively to deliver improved quality and efficiencies

What we will do together

- We will work with our population to ensure they are involved in decision making at all stages of planning and delivery
- We will work as health and care partners, considering the opportunities for person centred integrated delivery for every decision we make
- We will focus on early intervention and prevention to support people to avoid increasing levels of support / cost
- We will use the best available evidence to support our decision making

How we will work

- Our Place Based Partnerships will drive our integrated health and care approach, bring together the planning and delivery of integrated care
- We will have transparency in our decision making, sharing financial and outcomes information to reach a collective decision
- We will hold ourselves accountable for working to these principles and for the delivery of integrated health and care, recognising the statutory responsibilities of each partner

VALUES

- We will be open and honest with each other
- We will be respectful in working together
- We will be accountable, doing what we say we will do and following through on agreed actions

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Section 2

Reviewing the 22/23 BCF plan

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2022/23 BCF Plan Review

During 22/23 we completed a Root and Branch Review of the BCF. This review is a key component to developing our future system-wide collaborative commissioning approach in order to maximise opportunities for collaborative commissioning, pooled resources and the delivery of integrated services to improve outcomes for the population and achieve best value for money.

The aim of the root and branch review was to understand how we can better use the BCF as a vehicle to join up health and care services across a wide range of services such as public health, support for unpaid carers, housing support and community initiatives.

The initial review findings have highlighted the potential of the BCF to drive our system ambitions for integration and enable us to achieve the three principles set out in the Integrated Care Strategy:

1. Prevention is better than cure
2. Equity is everything
3. Integration by default

2022/23 BCF Plan Review

The review made specific recommendations to identify opportunities for greater collaboration in the following areas:

Early Help and Prevention

Integration of lifestyle reaching health inclusion advice services (e.g. smoking, alcohol and weight management support) with health and care pathways e.g. delivery of smoking cessation services in partnership with maternity services

Maximising the effectiveness of a range of developing navigation and support worker roles e.g. social prescribing, navigators, community workers, health coaches).

Proactive Care

Integration of MDT case management and development of PCN Neighbourhood teams e.g. health, social care, housing and VCS input (frailty, falls and wider complexities e.g. substance misuse and mental health.

Outcome and impact monitoring and our ability to plan demand and capacity for admission avoidance

Discharge to Assess

Integration of housing support, adaptation and temporary accommodation

Ability to meet complexity of need at home (P1)

P2 and P3 bed commissioning review (including MH flow)

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Learning Laboratories

A series of 'learning laboratories' took place in 22/23 bringing together partners to explore how different commissioners and providers can work together on specific integration projects. The laboratories were a mix of system-wide and place-based issues and were designed to explore what the barriers and enablers are to this collaborative approach.

The key findings were:

- the importance of a shared vision and understanding
- that a greater focus on prevention is needed
- there are challenges around identifying appropriate scope and focus (place/system).

The learning from these laboratories is informing our BCF plans as we continue to explore areas for increased collaboration.

As a system Nottingham and Nottinghamshire are committed to a greater emphasis on prevention, as evidenced in our new ICS strategy.

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Section 3

Governance and system engagement

Governance of our 2023 - 25 BCF plans

The **City Health and Wellbeing Board** has delegated responsibility for the BCF to the Health and Wellbeing Board Commissioning Sub-Committee.
The Sub-Committee is jointly chaired by Nottingham City Council and Nottingham and Nottinghamshire ICB.

The **Nottinghamshire County Health and Wellbeing Board** is responsible for oversight of the BCF.

An **ICS BCF Oversight Group** meets quarterly to oversee planning and performance for the BCF. The group has representatives from commissioning, finance and transformation workstreams from the ICB and both local authorities. This group jointly plans and creates the BCF plan with input from wider commissioners and programmes. Expenditure and scheme level plans are produced at HWB level.

System engagement and oversight of BCF Plans

A "Collaborative Commissioning Oversight Group" (CCOG) has been established to provide ongoing leadership for new ways of commissioning. The is group is a collaboration of NHS and Local Authority commissioners. As well as providing leadership and co-ordination for specific areas of collaborative commissioning, the group will inform system development priorities, including the development of integrated delivery approaches at Place.

CCOG will provide the strategic steer to the BCF Oversight Group, supporting the development of a 23-25 BCF Plan and ensuring this reflects changes to commissioned services and collective oversight of resources and outcomes.

Wider partners including Providers, Local Authority service leads and the third sector are engaged in the plan at scheme level. The schemes which comprise the Additional Discharge Fund have specific system –wide oversight from the **ICS Operational Discharge Steering Group** and through that group to the **Ageing Well Board**. Work will continue to develop collaborative commissioning approaches to Place Based Partnerships during 23-25 with the BCF as a key enabler to integration

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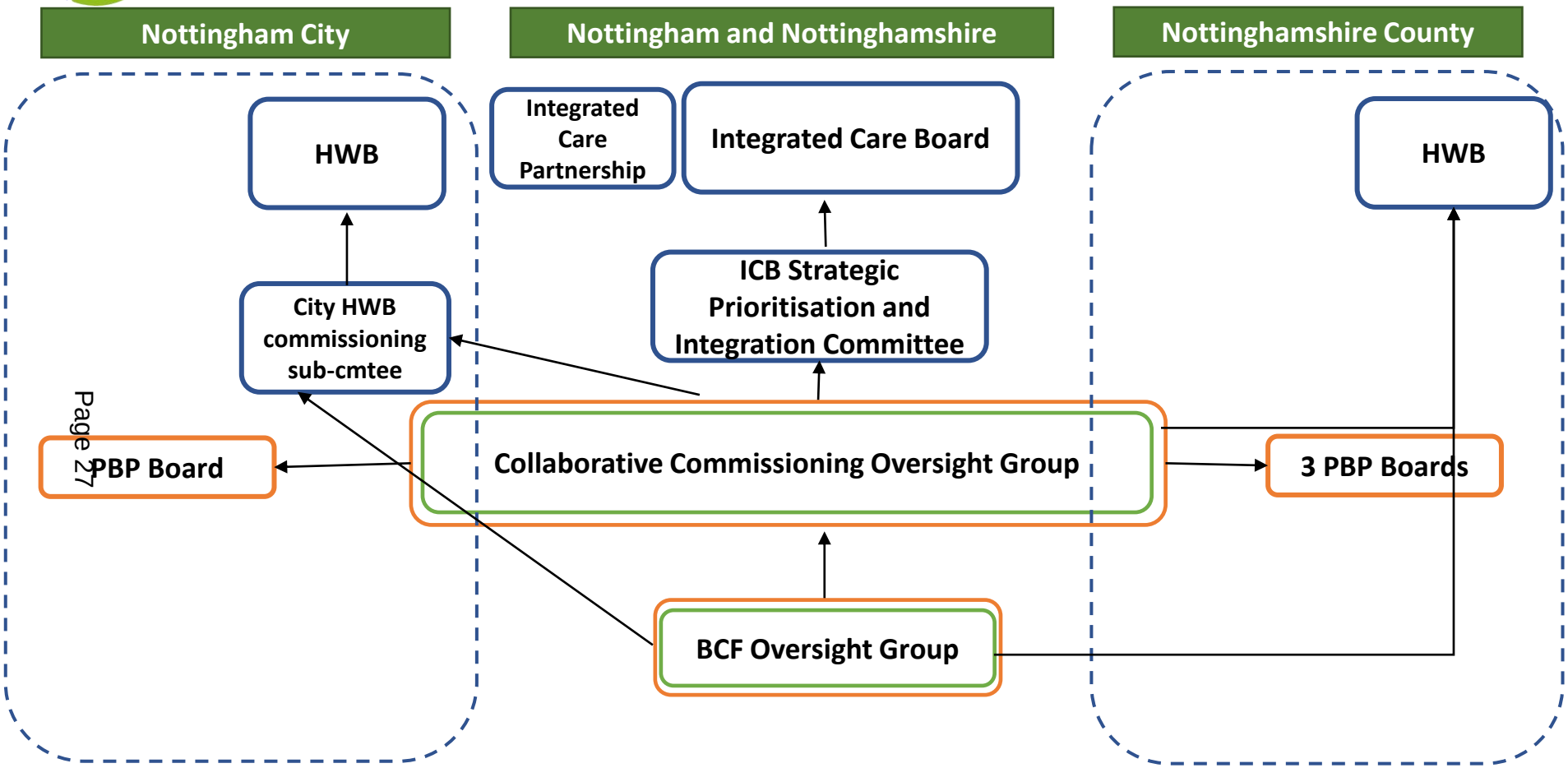
Collaborative Commissioning Governance

This slide shows the governance and oversight which aligns development of integrated delivery at Place and strategic oversight to commissioning



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Section 4

BCF Plans 2023 - 25

Developing our BCF plans for 2023 - 25

The 2023-25 BCF Plan provides our structured approach to joint planning between ICB and Local Authority. The BCF provides a vehicle to join up health and care services with wide ranging services such as public health, support for unpaid carers, housing support and community initiatives. These cover a range of evidence based commissioned services, provisions and intentions (as per SCIE logic model Logic model for integrated care | SCIE). Locally, we have agreed to describe these in our BCF plan under the following three themes:

Prevention and early intervention services: e.g. healthy lifestyle support, single point of access and support to navigate services, supported self-care

Anticipatory Care Services e.g. care co-ordination and multi-agency assessment and care planning, homecare and reablement, urgent care / crisis response, housing and assistive technology, primary care enhanced services

Discharge to assess services: integrated discharge teams, community beds, interim placements, homecare, reablement, housing support schemes.

Our BCF planning approach has been strengthened through the joint planning required to agree the Additional Discharge Funding, which linked BCF planning to our ICS –wide urgent care forums and reported through to our Ageing Well Board. We will continue to work with our developing Place Based Partnerships to realise the potential for BCF to support effective integrated service delivery and improved community wellbeing at Place and neighbourhood level, supported by BCF system oversight.

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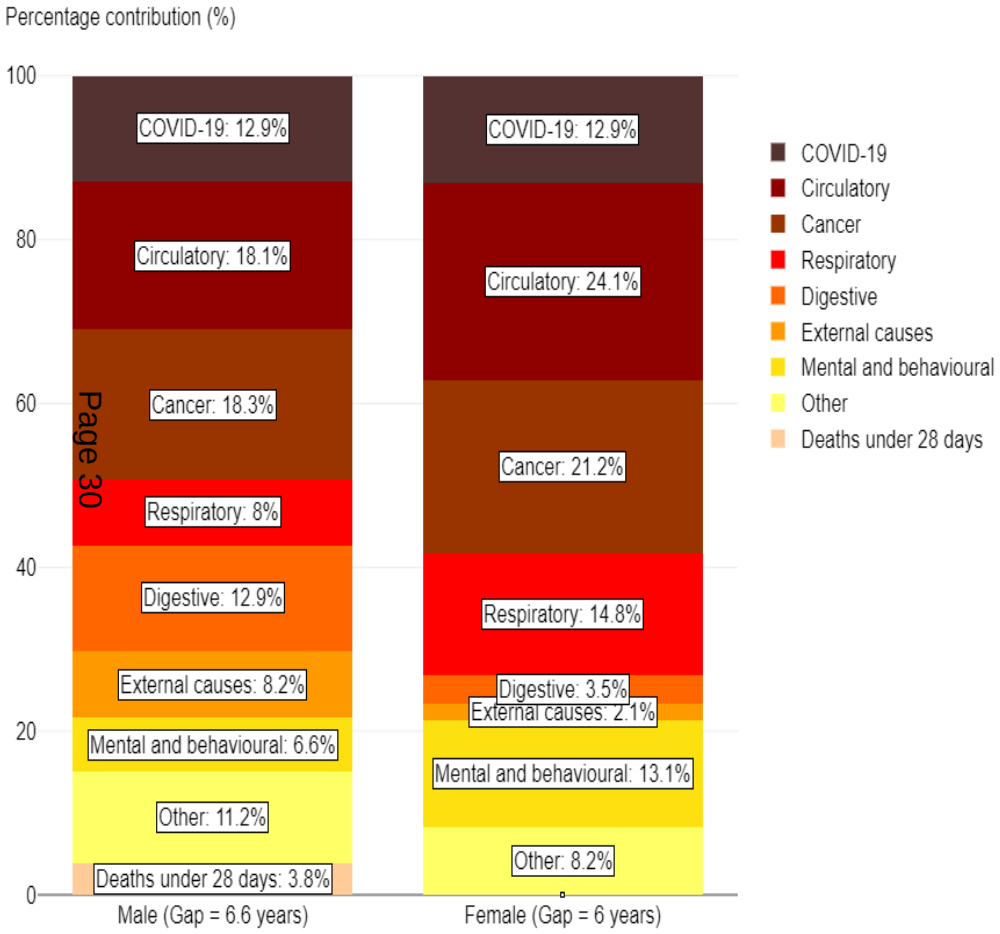
Accelerating our Health Inequalities Approach



Within our ICS, people in the most deprived areas have a life expectancy of around 6-7 years lower and spent 14 years longer in poorer health than those in the least deprived areas. Circulatory diseases (CVD), Cancer and Respiratory Conditions are some of the leading causes for this gap in life expectancy, disproportionately affecting people in more deprived areas and in many cases can be preventable.

Smoking rates are higher in the most deprived areas of the ICS, with Mansfield having the 3rd highest smoking rates in England. Smoking can increase the risk of CVD, Respiratory Conditions and Cancer.

Circulatory diseases (CVD) are the largest cause of life expectancy gap in the ICS with hypertension being the largest modifiable risk factor in its development. Obesity, diet and lifestyle factors can increase the risk of hypertension which is also more prevalent in areas of high deprivation and is also a key clinical area in the Core20Plus5 approach. Preventive lifestyle interventions could reduce the risk of hypertension and CVD development in the most at risk populations

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Accelerating our Health Inequalities Approach

- **The Core20Plus5 Approach** to tackling health inequalities underpins the NHS approach to tackling health inequalities across the ICS. The approach focuses on improving outcomes for the 20% most deprived populations across the ICS as well as "plus" populations identified as having some of the worst health outcomes. These are the groups which should be considered foremost when service planning to help reduce health inequalities. This targeted approach can be taken at all points of the care model, including prevention, proactive care and discharge to access services.
- Building an equitable health and care system is also a key approach taken by the ICS to reduce health inequalities. This includes delegating resources to areas where the need is the greatest or taking different more flexible approaches when considering access to services for different populations. This can be considered when addressing early help and prevention needs as well as proactive care.
- Over 40% of the population aged 65 and over in Nottingham City are classed as living in an area with high deprivation. Higher deprivation is associated to higher morbidity and lower life expectancy. People living in more deprived areas of Nottinghamshire are also more likely to report having a disability or life limiting illness. Disabled people are more likely to live in poverty, have less access to education and employment, and experience poorer ratings of personal wellbeing compared with non-disabled people. People with disabilities may also struggle to have their voices heard within services and may require more flexibility from the health and care system in order to access services. Where this flexibility is not available, it can impact on access and experience of care and result in people not receiving the care they need.
- Use of urgent and emergency care for Long Term Condition management is more common in areas of higher deprivation, and people in the most deprived quintiles have increased rates of multi-morbidity compared with those in the least deprived deciles. Anticipatory care will benefit these cohorts by providing targeted proactive and personalised care to help improve quality of life and condition management, aiming to reduce the need for hospitalisations.
- Carers are twice as likely to suffer from poor health compared to the general population, primarily due to a lack of information and support, finance concerns, stress and social isolation. Young carers feel say they feel invisible and often in distress, with up to 40% reporting mental health problems arising from their experience of caring.

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Priority area 1: Early Help and Prevention

Prevention, as defined in the Care Act Statutory Guidance (2016), is about **the care and support system actively promoting independence and wellbeing**. This means intervening early to support individuals, helping people retain their skills and confidence, and preventing need or delaying deterioration wherever possible

Priorities for 2023 - 24 include how lifestyle advice services could be more integrated with health and care pathways, and also how to maximise the effectiveness of a range of navigation and support worker roles. We'll look to maximise opportunities to support strength based and personalised approaches across health and social care to support independence, wellbeing and to prevent ill health.

Our 2023 - 25 areas of focus within the BCF plan include the procurement of new services to support unpaid Carers in line with the new joint strategy, plus early intervention, access to advice, information and coordinated support. This recognises the benefit brought by the Health and Wellbeing Board strategy to focus on the wider determinants on improving health and wellbeing through community focused approaches.

Priority area 1: Early Intervention and Prevention: Our Support to Unpaid Carers

Support to unpaid carers is a priority area of collaborative commissioning which will increase early intervention and improve services. The system completed the ICS Carers strategy in 22/23, a key achievement which was jointly developed between Nottingham City and Nottinghamshire Councils, ICB and co-produced with Carers, Providers and VCSE. The strategy is hinged on 10 key components developed by carers, and 'I' statements have been formulated to describe what good looks like. In response, partner organisations have developed 'we' statements to say what they should be doing in order to make sure carers needs are met. The carers support services that form part of our BCF plans support the implementation of the strategy.

Identification and early support

Vision: Carers should be identified and offered support at the earliest opportunity ie. At the point of diagnosis/discharge

'I' statements	'We' statement	BCF support
• I want to be able to access information and support when I need it • I would like support at first contact to understand my situation • I would like help to understand what a carer is	• We will work together with key partners across the system to identify carers and provide signposting and support. This will include GP practices, schools, healthcare providers (including hospitals) and care providers	• Carers hub in place City/County provide information & signposting to carers. • In 23/24 single hub to be commissioned ensuring consistent service offer across the ICS. Hub will be commissioned to support GP practices to identify carers. • Young carer specific service giving advice/signposting & support to understand their

Priority area 1: Early Intervention and Prevention: Our Support to Unpaid Carers

Carers will continue to be involved in overseeing the implementation of the strategy. This piece of work has also laid the foundation for the approach to collaborative commissioning moving forwards. The strategy will provide guidance and structure to the collaborative commissioning and procurement of high quality carers services during 23/24 which are designed to respond to the 'I' statements. We are also working with our places to ensure that carer support is tailored to our diverse populations. This will lead to improved outcomes for carers, increased return on investment and opportunities to increase early intervention and integration across health and care. We will embed the changes and monitoring of these new services in our BCF Plans.

Scope of Services to Support Unpaid Carers

Carers Hub – a single point of access for information and advice. This will include assessment and support planning

- Education, training and engagement with schools, employers and health and care professionals

Carers respite- to provide breaks from caring with a flexible offer to include home based breaks and residential breaks.

Young Carers Service- information, advice, support and activities.

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Priority area 1: Prevention and Early Intervention Schemes

Nottingham City	
Early Intervention	*Scheme ID 2 Care Navigation and Planning* *Scheme ID 13 Carers, Advice and support, respite service* *Plus embedded early intervention and prevention approaches across delivery of adult social care schemes (note some scheme/spend shown in 2- Ageing Well – anticipatory care model)* *Integration of community connections, Primary Care Networks and support roles e.g. social prescribing*

Nottinghamshire County	
Early Intervention	*Scheme ID 12 Carers Short Breaks* *Scheme ID 19 Carers respite* *Scheme ID 21 Carer Advice and Support* *Scheme ID 22 'Supporting People'* *Scheme ID 27 Enabling Care Act statutory responsibilities* *Plus embedded early intervention and prevention approaches across delivery of adult social care schemes (note some scheme/spend shown in 2- Ageing Well – anticipatory care model)* *Integration of community connections, Primary Care Networks and support roles e.g. social prescribing*

Priority area 2: Proactive Care model

As a system we are committed to developing our preventative approach to ensuring frail older people receive the right care, at the right time, in the right place. Across 5 PCN pilot sites, we are testing and developing our proactive approach to moderate and severely frail people, by focussing primary care led MDT's on reaching out to this population and having a personalised conversation in line with the national operating framework for Proactive Care. We know that all communities are different, and we are ensuring that our model is reflective of our communities. We are doing so in line with the PHM data that informs us of the key health and social care risks for each community to ensure its an evidence based preventative conversation. We are engaging with all key stakeholders to ensure they are part of our single neighbourhood level team who will be working with this population anyway.

The plan is to evaluate the pilots, understand the early indicators of success, as we know prevention doesn't yield a reduction in emergency admissions immediately, in order to inform our 23/24 priority areas.

In Nottingham and Nottinghamshire, Urgent Community Response (UCR) providers respond to both level one and level two falls (as per the Association of Ambulance Chief Executives definition). Moving forwards, the ambition it to expand upon the direct referrals into UCR from Care Homes as well as Technology Enabled Care (TEC) providers. This is expected to divert demand away from the ambulance service and into UCR, resulting in more patients who have fallen being managed in their own home, or usual place of residence, as opposed to a hospital admission.

Priority area 2: Proactive Care model

Additionally, in 23/24 work will be undertaken locally to:

- Review the existing falls prevention and management interventions and pathways
- Development of evidence-based strength and balance provision
- Targeted support to care homes
- Upskilling the clinical workforce
- Developing integration between UCR and the EMAS Community First Responder model
- Systems plans to establish a Frailty admission avoidance virtual ward in 23/24

We have a system wide approach to addressing health inequalities and a **really strong foundation of data through our Strategic Analytics and Information Unit** which is operational across the ICB. We can demonstrate that we know where each of our PHM target cohorts reside, the risk factors and link with touchpoints for NHS services. We are working hard as a system to expand this out into social care data too.

This work continues to be informed by the **Community transformation work during 23/24** – increase integration between health and care services at Primary Care Network level, this programme is enabling strong partnerships and improved relationships by connecting commissioned delivery with local communities and joint delivery models with VCS organisations to enable joined up care that is connected to local communities.

Priority area 2: Disabled Facilities Grant and Housing Integration

In 2023/24, the ICB and LA are supporting Housing Teams and Acute Hospitals to refresh the Housing Hospital Discharge protocol in the light of Transfer of Care Hub implementation. This protocol provides a partnership commitment to early identification (before medically fit) and duty to refer in the hospital and response from housing teams to ensure prioritised MDT assessment of individual's needs. This should therefore avoid delays. Once refreshed and agreed we will include within our BCF Oversight governance and ensure monitoring and feedback loops are embedded through the Urgent Care system governance.
The protocol also ensures appropriate input during hospital stays for people with complex needs and that wraparound support is in place when people leave hospital e.g. specialist homelessness services.

We have two local joint housing schemes to support the BCF objectives. The two schemes have been developed by councils with significantly high levels of housing and health inequality and are an integral part of the Transfer of Care Hub team, providing a housing expertise and highly flexible problem-solving h to patients at risk of a housing related discharge delay. The team take on the communication with housing assessment and arrange rapid housing interventions and provide support to the patient and their family to support them through housing change

Disabled Facilities Grant is recognised across Nottinghamshire as playing a vital role in creating safe and suitable home environments that prevent falls and other incidents in the home, promote independence and minimise care requirements. The need for strategic drive and oversight has been recognised and a new Adaptation for Independence Strategic Oversight Group has been established. This group aims, with the support of Foundations, to build collaborative working, use data to inform planning and evidence impact. A key priority for partners in 2023-24 is to consider financial challenges, within a county where districts and boroughs experience quite varying budget allocations, not proportionate to demand. A central framework agreement for the purchase of stairlifts will also require review in 2023-24.

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Priority area 2: Proactive Care Schemes

(note historic scheme labelling means that City and County expenditure can not be compared on a scheme by scheme basis)

Nottingham City	
Care Coordination and Navigation	*Scheme ID 1 – CityCare 'Out of Hospital Contract' MDT, LTC case management, specialist nurses and NCGPA Social Prescribing*
Primary Care Enhanced Services	*Scheme ID 7- GP Practice enhanced services for case management, MDT and coordination with specialist teams*
Urgent Care/2 hr Crisis	*Scheme ID 3 – CityCare 'Out of Hospital Contract' 2hour response service*
Housing & Tech	*Scheme ID 10,11,12- Assistive Technology – telehealth, dispersed alarms, equipment* *Scheme ID 14 – Housing Health – Hospital to Home, supporting prevention and D2A* *Scheme ID 15- Disabled Facilities Grant*
Nottinghamshire County	
Care Coordination and Navigation	*Scheme ID 5 and 8 NHT South Notts/Mid Notts case management, MDTs and specialist nursing)*
Primary Care Enhanced Services	*Scheme ID 4 – GP Practice enhanced services for case management, MDT and coordination with specialist teams* *Scheme ID 20 Care Home Quality*
Urgent Care	*Scheme ID 6 British red cross 2 hour response* *Scheme ID 7 South Notts NHT 2 hour response* *Scheme ID 11 Evening and night nursing* *Scheme ID 13 ED Front Door and streaming (SFHT acute)*
Housing & Tech	*Scheme ID 26 – Disabled Facilities Grant* *Scheme ID 24- Supported accommodation younger adults* *Scheme ID 25 Direct Payments for older and younger adults*

Priority area 3: Our Discharge to Assess model

Plans for improving discharge and ensuring that people get the right care in the right place:

At the heart of our D2A model is the ethos of 'home first' aiming to reduce the risks associated with patients who are medically safe remaining in an acute hospital any longer than necessary once they are medically safe for transfer (MSFT). D2A is comprised of three pathways: Pathway 1 (P1) – discharge home with reablement, Pathway 2 (P2) – discharge to bedded facility for reablement prior to discharge home and Pathway 3 (P3) – discharge to bedded facility for reablement and assessment for potential long-term care placement.

During 2023-24 we will continue to invest in and transform our P1 offer and are working towards integrating health and social care teams to provide the support patients need at home after hospital discharge. This will improve patient outcomes by reducing time spent in hospital, providing earlier reablement and rehabilitation to maximise functional outcome and reduce demand on long-term homecare and placements. We will continue to invest in the developing Transfer of Care Hubs, which will be fully embedded by 2024-25 ensuring that capacity is increased so that there is 7 day working across the P1 offer and that this is in place before winter. We are also planning to review current mental health support in community to work alongside the P1 model to support frail patients, including those with dementia and delirium. Work is ongoing to transform P2 and P3 to right size capacity and reduce length of stay in existing beds, the P2 and P3 transformed offer will be mobilised in 2024/5.

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Priority area 3: Our Discharge to Assess model

As a system we continue to develop and embed progress against the **High Impact Change Model** themes identified from ICS "What Good Looks Like" workshop held 8th September 2022. These themes are system data, culture change, embedding the discharge to assess approach of "Home First "and integration. Progress in 22/23 includes implementation of three multi-agency Transfer of Care Hubs built on Trusted Assessor principles, significant investment into Pathway 1 capacity across Health and Social Care to enable more people to go "Home First", ongoing development of an ICS D2A "One Version of the Truth" data set starting with the Transfer of Care Hubs and system wide workshops and rolling programmes of work to embed culture change and integration.

Collaborative Commissioning Progress: A collaborative commissioning review in 2022/23 resulted in a system wide agreement to a pooled funding investment for additional capacity across services to support improve delivery of the 'Pathway 1' integrated business case. This additional resource continues to be a system priority this year and is supported by a joint service specification, shared data monitoring and performance oversight. This is being supported by the ICS System Analytic Insight Unit and a single Urgent Care dashboard is in development. During 2023-25 we will continue to prioritise P1 across the system and model capacity accordingly.

Priority area 3: Our Approach to Capacity and Demand Modelling to Support Discharge from Hospital

Learning from 2022/23:

During 2022/23 there was an ambition to increase P1 capacity to a level where 300 P1 discharges could be made each week. P1 capacity has increased and allowed us to make progress towards this ambition but further work will still be required in 2023/24 to achieve this.

As the P1 capacity is still growing there were instances where P2 beds or P1 interim beds had to be used as an alternative. Work will continue into 2023/24 to increase P1 capacity to ensure the ideal pathway is followed.

Delays in P1 reablement services have significantly reduced in the second half of 2022/23. There has also been a reduction in the average length of stay for P2 beds, and we have been able to decommission a number of interim beds too.

Approach to estimating demand, assumptions made and gaps in provision identified:

The direction of travel will be to continue to increase P1 capacity in order to reduce delays in the discharge pathway and reduce unnecessary transfers to a Pathway 2 bed or interim bed.

The demand and capacity plans support our aims of increasing Pathway 1 capacity to reduce delays, improve flow and right size capacity across the ICS. This is reflected in the wider BCF plans.

Our available datasets do not clearly differentiate between rehabilitation and reablement at this point in time, therefore for the purposes of the BCF plan all Pathway 1 activity is assigned to reablement and all Pathway 2 activity is assigned to rehabilitation. Capacity planning has taken into account bed base, caseload and the number of hours of care provided per person. Phasing has been split into equal 1/12ths as last years data shows a relatively stable monthly pattern throughout the year for discharges.

Priority area 3: Our Discharge to Assess schemes

(note historic scheme labelling means that City and County expenditure can not be compared on a scheme by scheme basis)

Nottingham City	
Integrated Discharge Team	*Scheme ID 4, 8,9- Facilitating Discharge, integrated enablement teams and supporting D2A. Mental Health integrated discharge*
Rehab/reablement	*Scheme ID 4, 6- reablement, rehabilitation and homecare provision.*
Community beds	*Scheme ID 4 City Care 'out of hospital' contract community beds*
Housing	*Scheme ID 15 Hospital to Home – housing advice to D2A, minor adaptations and 'handyperson' type support.*

Nottinghamshire County	
Integrated Discharge Team	*Scheme ID 3 Support to Integrated Discharge planning* *Scheme ID 15 Bassetlaw Mental health discharge roles* *Scheme ID 16,17, 18 Bassetlaw Discharge and assessment teams (across acute, mental health and community)*
Rehab/reablement	*Scheme ID 1- Short term rehab (NHT lot 10 South Notts)* *Scheme ID 9 and 10- Falls Prevention (NHT Mid Notts Community Rehab falls and South Notts East Bridgford Falls Rehab)*
Community beds	*Scheme ID 2- Community beds (NHT Lot 8- South Notts Lingsbar and Mid Notts Fernwood)* *Scheme ID 23- Nursing and dementia interim placement*
Housing	*Housing support to D2A 'ASSIST' under review*

Priority area 3: Additional Discharge Funding

In 2022/23 Adult Social Care Discharge Funding was made available to ICS's to build in additional adult social care and community based reablement capacity, to facilitate timely discharges from hospital during the peak winter period. The system used this opportunity in a number of ways including increasing bedded capacity and resourcing recruitment initiatives across care pathways.

In 2023-24 Additional Discharge funding is again being provided to enable local areas to build additional adult social care and community-based reablement capacity to reduce delayed discharges and improve outcomes for patients. The total funds of £4.335m for Nottinghamshire County Council and £2.328m for Nottingham City Council and £5.710m for the Integrated Care Board. There is a requirement that the ICB expenditure of the funding is agreed with the relevant Health and Wellbeing Board, and the population-based methodology has been applied to apportion the funding as in 2022/23.

The system used the learning from the 2022-23 schemes and stakeholders have taken the collective view to continue to fund those schemes which added capacity during 2022/23 and had a proven impact upon discharge. This includes a particular focus on Pathway 1 as an agreed system priority; Nottingham City has significantly improved it's discharge position for P1 waits in 2022/23 as a result of last years winter discharge funding. The proposal for 2023/24 is to focus on P1 and seeks to continue to support and maintain the resilience created within the external homecare market which has resulted in waits for P1 discharge being maintained in single figures since march 2023. Nottinghamshire are also committed to a resilient P1 pathway and are also proposing using the fund to add resilience to the broader workforce.

Robust governance of the Additional Discharge Funding is provided through the Ageing Well Board with regular oversight and impact monitoring to be provided via the ICS Operational Discharge Group moving forwards.

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Priority area 3: Our Additional Discharge Schemes

Please see slide 32 for the rationale behind the schemes for each HWB

Nottingham City	
Integrated neighbourhood services	*Scheme 28 Urgent Community Response*
Rehab/reablement at home to support discharge	*Scheme 27 & 29 Pathway 1 discharge programme*

Nottinghamshire	
Integrated neighbourhood services	*Scheme 35 Urgent Care Community Response*
Reablement at home to support discharge	*Scheme 34 Pathway 1 discharge programme*
Reduce delayed discharges supporting the principles of D2A	*Scheme 36 additional staffing capacity*
Planning services in advance and enabling providers to recruit to their workforce	*Scheme 37 Extended voluntary sector capacity, bespoke landing pages vacancies*
Additional capacity (learning from previous funding)	*Scheme 38 Mental health step up/down beds, surge homecare provision/bed capacity*
Improving collaboration and information sharing across health & social care	*Scheme 39 Mental Health Hospital Discharge Commissioner, Strategic system transformation posts, development integrated therapy training, development integrated working community health and social care reablement*

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Section 5

Summary of changes to 23/25 plan

Summary of Changes to 23 -25 Plan

23-25 Change to Nottinghamshire County HWB BCF Plan

The Additional Discharge Funding (detailed on the previous slides) is an addition to the BCF plans this year.

Support for unpaid carers will be re-commissioned within 2023/24 and a new service across the ICS area will provide consistent service provision across City and County.

23 – 25 Changes to Nottingham City HWB BCF Plan

The Additional Discharge Funding (detailed on the previous slides) is an addition to the BCF plans this year.

Support for unpaid carers will be re-commissioned within 2023/24 and a new service across the ICS area will provide consistent service provision across City and County.

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Appendix 1

Nottinghamshire – Personalised Commissioning £37 million

Protecting social care - £14,490,518
This is expected to meet an increase in demand for Direct Payments for Ageing Well and Living Well.

Ageing Well:
The anticipated increases comprise of home care provision to enable people to remain living independently at home, prevention of avoidable hospital admissions, and to reduce or delay admissions into long-term care home placements. Service users are allocated a personal budget in the form of a Direct Payment which they use to arrange and manage their own care and support packages.

Living Well:
There are considerable budget pressures arising from the increased demand for large complex packages of care to support people with learning disabilities to remain living in the community.

Improved Better Care Fund - £22,824,301
The IBCF has been used to contribute to funding care packages, the increase in the complexity of needs has been seen across the adult social care demographic. Community provision has meant more people require bespoke community provision to meet their needs, this has led to increases in gross package costs. Combined with annual inflationary increases this has led to increased budget pressures across adult social care. The IBCF has been used to help fund the increased pressures relating to both gross package increases and inflationary uplifts which has helped to sustain the adult social care market.

BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Nottingham	
Completed by:	Katy Dunne	
E-mail:	katy.dunne@nhs.net	
Contact number:	Teams	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no please indicate when the HWB is expected to sign off the plan:	Wed 26/07/2023	<< Please enter using the format, DD/MM/YYYY

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Linda	Woodings	linda.woodings@nottinghamcity.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Dr	Amanda	Sullivan	amanda.sullivan7@nhs.net
	Additional ICB(s) contacts if relevant		Sarah	Fleming	sarah.fleming@nhs.net
	Local Authority Chief Executive		Mel	Barrett	mel.barrett@nottinghamcity.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Catherine	Underwood	catherine.underwood@nottinghamcity.gov.uk
	Better Care Fund Lead Official		Katy	Ball	katy.ball@nottinghamcity.gov.uk
	LA Section 151 Officer		Ross	Brown	ross.brown@nottinghamcity.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->					

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Nottingham

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,768,450	£2,768,450	£2,768,450	£2,768,450	£0
Minimum NHS Contribution	£29,089,765	£30,736,246	£29,089,765	£30,736,247	£0
iBCF	£16,602,807	£16,602,807	£16,602,807	£16,602,807	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£2,327,688	£2,327,688	£2,327,688	£2,327,688	£0
ICB Discharge Funding	£1,988,915	£1,988,915	£1,988,915	£1,988,915	£0
Total	**£52,777,625**	**£54,424,106**	**£52,777,625**	**£54,424,107**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£8,266,486	£8,734,369
Planned spend	£12,468,429	£13,154,957

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£15,776,825	£16,669,794
Planned spend	£15,820,908	£16,749,321

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	272.1	267.2	269.8	269.7

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,902.4	1,902.4
	Count	742	742
	Population	38098	38098

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	93.8%	94.3%	94.0%	95.3%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	1,025	1,677

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.3%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Nottingham

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month.
The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:
- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.
You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:
- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Demand from Hospital Discharges
	The ICS report on the number of discharges from acute hospitals using data direct from Nervecentre.
	Hospital discharges from between April 2022 and March 2023 have been used to set the baseline number in the draft return. No growth assumption has been applied to this baseline figure.
	For the draft return no phasing has been applied with all months equal.
	The same baseline period has been taken for patients discharged from a Mental Health in-patient bed and these are also included in the return based on the discharge destination. It has been assumed that 20% of NWCT patients discharged to their usual place of residence will require pathway 1 support in the

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
(Please select Trust/s.....)	Social support (including VCS) (pathway 0)												
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST													
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST													
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST													
OTHER													
(Please select Trust/s.....)	Reablement at home (pathway 1)												
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST		302	302	302	302	302	302	302	302	302	302	302	302
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST		6	6	6	6	6	6	6	6	6	6	6	6
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST		43	43	43	43	43	43	43	43	43	43	43	43
OTHER		15	15	15	15	15	15	15	15	15	15	15	15
(Please select Trust/s.....)	Rehabilitation at home (pathway 1)												
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST													
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST													
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST													
OTHER													
(Please select Trust/s.....)	Short term domiciliary care (pathway 1)												
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST													
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST													
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST													
OTHER													
(Please select Trust/s.....)	Reablement in a bedded setting (pathway 2)												
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST													
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST													
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST													
OTHER													
(Please select Trust/s.....)	Rehabilitation in a bedded setting (pathway 2)												
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST		79	79	79	79	79	79	79	79	79	79	79	79
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST		8	8	8	8	8	8	8	8	8	8	8	8
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST		10	10	10	10	10	10	10	10	10	10	10	10
OTHER		4	4	4	4	4	4	4	4	4	4	4	4
(Please select Trust/s.....)	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)												
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST		24	24	24	24	24	24	24	24	24	24	24	24
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST		4	4	4	4	4	4	4	4	4	4	4	4
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST		8	8	8	8	8	8	8	8	8	8	8	8
OTHER		2	2	2	2	2	2	2	2	2	2	2	2
Totals	**Total:**	577	577	577	577	577	577	577	577	577	577	577	577

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	59	59	59	59	59	59	59	59	59	59	59	59
Urgent Community Response	0	1	2	3	4	5	6	7	8	9	10	11
Reablement at home	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation at home	91	91	91	91	91	91	91	91	91	91	91	91
Reablement in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation in a bedded setting	25	25	25	25	25	25	25	25	25	25	25	25
Other short-term social care	9	9	9	9	9	9	9	9	9	9	9	9

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			
Reablement at Home	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	60%	40%	
Rehabilitation at home	Monthly capacity. Number of new clients.	363	379	395	411	426	442	442	442	442	442	442	442	60%	40%	
Short term domiciliary care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	60%	40%	
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	83	83	83	83	83	83	83	83	83	83	83	83			
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	38	38	38	38	38	38	38	38	38	38	38	38	50%	50%	

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0			
Urgent Community Response	Monthly capacity. Number of new clients.	0	1	2	3	4	5	6	7	8	9	10	11	60%	40%	
Reablement at Home	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	60%	40%	

Rehabilitation at home	Monthly capacity. Number of new clients.	91	91	91	91	91	91	91	91	91	91	91	91	60%	40%		
Reablement in a bedded setting	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0				
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	25	25	25	25	25	25	25	25	25	25	25	25				
Other short-term social care	Monthly capacity. Number of new clients.	9	9	9	9	9	9	9	9	9	9	9	9	50%	50%		

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Nottingham

Local Authority Contribution			Complete:
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2	
Nottingham	£2,768,450	£2,768,450	Yes
DFG breakdown for two-tier areas only (where applicable)			
Total Minimum LA Contribution (exc iBCF)	**£2,768,450**	**£2,768,450**	

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2	
Nottingham	£2,327,688	£2,327,688	Yes

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2	
NHS Nottingham and Nottinghamshire ICB	£1,988,915	£1,988,915	Yes
Total ICB Discharge Fund Contribution	£1,988,915	£1,988,915	

iBCF Contribution	Contribution Yr 1	Contribution Yr 2	
Nottingham	£16,602,807	£16,602,807	Yes
Total iBCF Contribution	**£16,602,807**	**£16,602,807**	

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	No	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding	
				Yes
Total Additional Local Authority Contribution	**£0**	**£0**		

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Nottingham and Nottinghamshire ICB	£29,089,765	£30,736,246
Total NHS Minimum Contribution	**£29,089,765**	**£30,736,246**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	No	Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding	
				Yes
Total Additional NHS Contribution	**£0**	**£0**		
Total NHS Contribution	**£29,089,765**	**£30,736,246**		

	2023-24	2024-25
Total BCF Pooled Budget	**£52,777,625**	**£54,424,106**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Nottingham

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£2,768,450	£2,768,450	£0	£2,768,450	£2,768,450	£0
Minimum NHS Contribution	£29,089,765	£29,089,765	£0	£30,736,246	£30,736,247	-£1
iBCF	£16,602,807	£16,602,807	£0	£16,602,807	£16,602,807	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£2,327,688	£2,327,688	£0	£2,327,688	£2,327,688	£0
ICB Discharge Funding	£1,988,915	£1,988,915		£1,988,915	£1,988,915	£0
Total	**£52,777,625**	**£52,777,625**	**£0**	**£54,424,106**	**£54,424,107**	**-£1**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£8,266,486	£12,468,429	£0	£8,734,369	£13,154,957	£0
Adult Social Care services spend from the minimum ICB allocations	£15,776,825	£15,820,908	£0	£16,669,794	£16,749,321	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

>> Incomplete fields on row number(s):

#NAME?

									Planned Expenditure									
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Expected outputs 2023-24**	**Expected outputs 2024-25**	**Units**	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	Access & Navigation	Care Coordination CityCare 'Out of Hospital Contract' MDT, LTC case	Integrated Care Planning and Navigation	Care navigation and planning					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£1,088,332	£1,149,932	17%
2	Access & Navigation	Single Point of Access	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£434,847	£459,459	1%
3	Integrated Care	Integrated Care Team-CityCare 'Out of Hospital Contract' 2hour response	Urgent Community Response	Reablement at home (to prevent admission to hospital or residential care)					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£7,338,960	£7,787,297	14%
4	Integrated Care	Homecare Packages plus integrated team costs	Home Care or Domiciliary Care	Domiciliary care packages		137876.2	137876.2	Hours of care	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£2,357,727	£2,524,125	10%
5	Integrated Care	Care Navigation and Planning	Integrated Care Planning and Navigation	Care navigation and planning					Community Health		LA			Local Authority	Minimum NHS Contribution	Existing	£557,266	£588,807	2%
6	Integrated Care	Reablement/Rehabilitation Services	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£4,036,738	£4,265,217	11%
8	Primary Care	GP Practice Enhanced Services - case management, MDT and coordination	Prevention / Early Intervention	Risk Stratification					Primary Care		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£3,003,412	£3,173,406	28%

9	Facilitating Discharge	Integrated enablement teams supporting discharge	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£972,445	£1,027,486	3%
10	Facilitating Discharge	Mental Health teams	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,907,884	£2,015,870	5%
11	Assistive Technology	Telecare, Telehealth & Integrated jointly commissioned	Assistive Technologies and Equipment	Assistive technologies including telecare		7100	7100	Number of beneficiaries	Community Health		Joint	46.0%	54.0%	Local Authority	Minimum NHS Contribution	Existing	£334,400	£334,400	56%
12	Assistive Technology	Dispersed Alarm Service	Assistive Technologies and Equipment	Community based equipment		300	300	Number of beneficiaries	Community Health		Joint	46.0%	54.0%	Local Authority	Minimum NHS Contribution	Existing	£115,900	£115,900	15%
13	Assistive Technology	Assistive Technology Equipment	Assistive Technologies and Equipment	Community based equipment		7000	7000	Number of beneficiaries	Community Health		NHS			Private Sector	Minimum NHS Contribution	Existing	£21,078	£22,271	24%
14	Carers	Carers Advice and Support & Respite Service	Carers Services	Respite services		2545	2545	Beneficiaries	Community Health		Joint	100.0%	0.0%	Charity / Voluntary Sector	Minimum NHS Contribution	Existing	£714,040	£714,040	45%
15	Housing Health	Advice & Support	Housing Related Schemes						Community Health		NHS			Local Authority	Minimum NHS Contribution	Existing	£95,469	£100,873	100%
16	Disabled Facilities Grant	Adaptation, community equipment and assistive technology	DFG Related Schemes	Adaptations, including statutory DFG grants		210	225	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£2,768,450	£2,768,450	100%
17	Improved Better Care Fund	Stabilise care provider market	Workforce recruitment and retention						Social Care		LA			Local Authority	iBCF	Existing	£9,269,907	£9,269,907	6%
18	Improved Better Care Fund	Social Care reablement and early intervention OT	Home-based intermediate care services	Rehabilitation at home (to prevent admission to hospital or residential care)		1659	1659	Packages	Social Care		LA			Local Authority	iBCF	Existing	£1,269,521	£1,269,521	4%
19	Improved Better Care Fund	Complex needs healthcare services and reviewng officers	Home Care or Domiciliary Care	Domiciliary care packages		18500	18500	Hours of care	Social Care		LA			Local Authority	iBCF	Existing	£1,172,561	£1,172,561	3%
20	Improved Better Care Fund	Hospital Discharge Team	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	iBCF	Existing	£44,873	£44,873	0%
21	Improved Better Care Fund	Winter Pressures - interim beds held within internal provision to support winter	Residential Placements	Short-term residential/nursing care for someone likely to require a	Interim beds held within internal residential home				Social Care		LA			Local Authority	iBCF	Existing	£402,878	£402,878	1%
22	Improved Better Care Fund	Meeting adult social care needs (demand and complexity)	Other						Social Care		LA			Local Authority	iBCF	Existing	£3,271,472	£3,271,472	2%
23	Improved Better Care Fund	Nottingham Health and Care Point	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	iBCF	Existing	£24,445	£24,445	0%
27	P1 Discharge Programme	P1 Discharge Programme	Home-based intermediate care services	Reablement at home (to support discharge)		5200	5200	Packages	Community Health		NHS			NHS Community Provider	ICB Discharge Funding	Existing	£1,851,950	£1,851,950	21%
28	Urgent Care Community Response	Urgent Care Community Response	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	ICB Discharge Funding	Existing	£136,965	£136,965	3%
29	P1 Discharge Programme	P1 Discharge Capacity	Home-based intermediate care services	Rehabilitation at home (to support discharge)	Rehab at home to support discharge -	1430	1430	Packages	Social Care		LA			Local Authority	Local Authority Discharge	Existing	£2,327,688	£2,327,688	5%
7	Integrated Care	Integrated Care Teams - Duty, Community, City OT, Placement and Homecare	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£6,111,267	£6,457,164	17%
24	Improved Better Care Fund	Winter Pressures - Age UK Contract	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Social Care		LA			Local Authority	iBCF	Existing	£127,000	£127,000	0%
25	Improved Better Care Fund	Winter Pressures - Extension to dispersed alarm service	Assistive Technologies and Equipment	Assistive technologies including telecare		191	191	Number of beneficiaries	Social Care		LA			Local Authority	iBCF	Existing	£54,000	£54,000	7%
26	Improved Better Care Fund	Winter Pressures - Team costs (Nottingham Health and Care Point,	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Social Care		LA			Local Authority	iBCF	Existing	£966,150	£966,150	3%

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.

15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Nottingham

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	274.8	269.9	272.6	196.0	Avoidable admissions plan has been set on a smallish reduction on the quarterly actuals for 2022 23 (neither LA achieved the 2022 23 plans set last year). Both LA's benchmark well against their peer LA's for the avoidable admissions metric.	We are piloting primary care led MDTs across 5 PCN sites to test and develop our approach to ensuring that frail older people receive the right care at the right time in the right place. Pilots to be evaluated to understand early indicators of success to inform the priority areas for 2023/24	Yes
	Number of Admissions	725	712	719	-			
	Population	337,098	337,098	337,098	337,098			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Indicator value	272.1	267.2	269.8	269.7			Yes

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition	
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,371.6	1,902.4	1,902.4	Plan for 2023 24 has been set at a maintenance of the 2022 23 position as you can see there was a marked decrease in the number of falls / rate when compared to 2021 22. Urgent Care Response and Community First Responder Services in place and all EMAS conveyances to hospital from Care Homes are down by 10% approx, but as we only have the one	In Nottingham and Nottinghamshire, Urgent Community Response (UCR) providers respond to both level one and level two falls (as per the Association of Ambulance Chief Executives definition). Moving forwards, the ambition it to expand upon the direct referrals into UCR from Care Homes as well as Technology Enabled Care (TEC) providers. This is	Yes
	Count	925	742	742			Yes
	Population	38,098	38098	38098			Yes

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	93.4%	93.0%	93.6%	93.8%	The average of the main peers for Nottingham LA for 2022 23 discharges = 94.1%, almost the plan set for Nottingham last year, which was not quite achieved finishing at approx 93.3%. Above the England total of 92.6% for 2022 23.	During 2023-24 we will continue to invest in and transform our P1 offer and are working towards integrating health and social care teams to provide the support patients need at home after hospital discharge. This will improve patient outcomes by reducing time spent in hospital, providing earlier reablement and	Yes
	Numerator	6,073	6,088	6,102	6,126			
	Denominator	6,499	6,544	6,516	6,531			
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan			
	Quarter (%)	93.8%	94.3%	94.0%	95.3%			
	Numerator	6,515	6,506	6,202	6,287			Yes

	Denominator	6,945	6,899	6,595	6,596		rehabilitation to maximise functional	Yes

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	1024.9	609.9	1705.7	1677.0	Adult Social care has two transformation programmes supporting the reduction of residential placements	The first focuses on staff culture and alternatives such as extra care, to ensure that people are supported to maintain independence within the least restrictive possible setting. The second will focus on opportunities to maximise on the use of	Yes
	Numerator	401	246	688	688			Yes
	Denominator	39,125	40,334	40,334	41,025			

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	68.3%	80.0%	78.1%	80.3%	Waits for Reablement services remain in single digits with most citizens offered services within 24 hours of being referred for discharge	The Adult Social Care transformation programme will consider its reablement service, ensuring that it is efficient and effective and prevent readmisiion, seeking opportunities to enhance the knowledge and skills of its workforce whilst reducing	Yes
	Numerator	99	724	360	208			Yes
	Denominator	145	905	461	259			Yes

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

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