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NHS
Nottingham and Nottinghamshire
Clinical Commissioning Group

Nottingham City Council

Nottingham City Health and Wellbeing Board Commissioning Sub-Committee

Date: Wednesday 24 November 2021

Time: 4:00pm

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

Please see the information at the bottom of this agenda front sheet about the measures for ensuring Covid-safety

Governance Officer: Adrian Mann **Direct Dial:** 0115 8764468

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.

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6 **Future Meeting Dates**
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Wednesday 30 March 2022 at 4:00pm

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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- **asked to make use of the hand sanitiser available and, when moving about the building, follow signs about traffic flows, lift capacities, etc.**

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Nottingham City Health and Wellbeing Board
Commissioning Sub-Committee
Membership

Voting Members	
Nottingham City Council's Portfolio Holder with a remit covering Health and Adult Social Care	Councillor Adele Williams Portfolio Holder for Adults and Health
Director of Commissioning and Procurement, Nottingham City Council	Katy Ball (Co-Chair)
Head of Joint Commissioning, NHS Nottingham and Nottinghamshire Clinical Commissioning Group	Sarah Fleming (Co-Chair)
GP Lead, NHS Nottingham and Nottinghamshire Clinical Commissioning Group	Dr Manik Arora
Non-Voting Members	
Director of Public Health, Nottingham City Council	Lucy Hubber
Director of Adult Social Care, Nottingham City Council	Sara Storey
Head of Contracting and Procurement, Nottingham City Council	*Vacant*
Head of Commercial Finance, Nottingham City Council	Ceri Walters
Director of Children's Integrated Services, Nottingham City Council	Helen Watson
Assistant Director of Commissioning (Mental Health, Children and Families), NHS Nottingham and Nottinghamshire Clinical Commissioning Group	*Vacant*
Representative, Healthwatch Nottingham and Nottinghamshire	Sarah Collis Chair

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Nottingham City Council
Health and Wellbeing Board: Commissioning Sub-Committee

Minutes of the meeting held in the Ballroom, The Council House, Old Market Square, Nottingham, NG1 2DT on Wednesday 26 May 2021 from 4:00pm to 4:17pm

Membership

Voting Members

Present	**Absent**
Katy Ball (Chair)	None
Dr Manik Arora	
Sarah Fleming	
Councillor Adele Williams	

Non-Voting Members

Present	**Absent**
Sara Storey	Sarah Collis
	David Johns
	Steve Oakley
	Ceri Walters
	Helen Watson

Colleagues, partners and others in attendance:

Bobby Lowen	-	Lead Commissioning Manager, Nottingham City Council
Adrian Mann	-	Governance Officer, Nottingham City Council
Naomi Robinson	-	Senior Joint Commissioning Manager, NHS Nottingham and Nottinghamshire Clinical Commissioning Group

Call-in

Unless stated otherwise, all decisions made by the Health and Wellbeing Board: Commissioning Sub-Committee are subject to call-in. The last date for call-in is **Monday 7 June 2021**. Decisions cannot be implemented until the next working day following this date.

1 Changes to Membership

The Committee noted that David Johns has replaced Alison Challenger as Nottingham City Council's Interim Director of Public Health.

2 Apologies for Absence

Sarah Collis	(Chair, Healthwatch Nottingham and Nottinghamshire)
David Johns	(Interim Director of Public Health, Nottingham City Council)
Helen Watson	(Interim Director of Children's Integrated Services, Nottingham City Council)

3 Declarations of Interests

None.

4 Minutes

The Committee confirmed the minutes of the meeting held on 24 March 2021 as a correct record and they were signed by the Chair.

5 Better Care Fund Year-End Reporting Template 2020/21

Naomi Robinson, Senior Joint Commissioning Manager at NHS Nottingham and Nottinghamshire Clinical Commissioning Group (CCG), presented a report the Nottingham City Better Care Fund (BCF) year-end reporting template for 20/2021. The following points were discussed:

(a) the 2020/21 BCF reporting requirements were paused during the emergency response to Coronavirus. In recognition of the disruption and reduced capacity in local authorities and CCGs caused by the pandemic, the reporting requirements for the period were decreased significantly, including the omission of the usual performance metrics;

(b) the return contains feedback on the challenges experienced during the period, in addition to the cross-system partnership working carried out with members of the Local Resilience Forum. There has been a major focus on identifying the most vulnerable people and developing more proactive service responses. Strong work has been carried out with people affected by homelessness, and it is hoped to expand this into providing better support to help people into regularised accommodation. Hospital discharge systems are under review, along with home care provision;

(c) the Committee considered that it can be difficult to relate the programmes as set out in the reporting template to the actual outcomes for individual service users. Going forward in the post-Coronavirus context, it is important to work through what the BCF is achieving and how it is doing so, to link the outcomes for people to the BCF's priorities. Resources should be followed back from the person, to assess how services could be provided differently and more effectively. There are a number of opportunities for greater flexibility through effective co-production, and work is required to adapt to changing needs and developments, including in assistive technology and single-point access to healthcare services, such as through the NHS App;

(d) the Committee requested that discussions with members take place on the BCF going forward, to assess how the core issues and opportunities can be addressed, and what can be achieved through the BCF in terms of new joint commissioning approaches, which may be very different going forward.

Resolved to approve the submission of the 2020/21 Better Care Fund Year-End Template to NHS England & Improvement.

- Reasons for the decision

To comply with NHS England & Improvement's 2020/21 Better Care Fund national reporting requirements.

- Other options considered

To not submit a return: this option was rejected as the submission of the Better Care Fund year-end template to NHS England & Improvement is a national requirement.

6 Future Meeting Dates

Resolved to meet on the following dates:

- **Wednesday 28 July 2021 at 4:00pm**
- **Wednesday 29 September 2021 at 4:00pm**
- **Wednesday 24 November 2021 at 4:00pm**
- **Wednesday 26 January 2022 at 4:00pm**
- **Wednesday 30 March 2022 at 4:00pm**

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Nottingham City Health and Wellbeing Board
Commissioning Sub-Committee
24 November 2021

	Report for Resolution
Title:	Better Care Fund Plan 2021-22
Lead officer(s):	Sarah Fleming – Head of Joint Commissioning, NHS Nottingham and Nottinghamshire Clinical Commissioning Group
Author and contact details for further information:	Naomi Robinson – Senior Joint Commissioning Manager, NHS Nottingham and Nottinghamshire Clinical Commissioning Group naomi.robinson2@nhs.net
Brief summary:	This paper presents the Better Care Fund (BCF) 2021/22 Planning Template and BCF Narrative Plan for agreement. The plan continues to include a range of services aimed at supporting people to live independently in the community and enablers to provide integrated services to improve outcomes. The BCF Planning requirements 2021/22 include baseline data for three new performance metrics and the requirement to set stretching targets. These are: • unplanned hospitalisation for chronic ambulatory care sensitive conditions; • reducing length of stay in hospital, measured through the percentage of hospital inpatients who have been in hospital for longer than 14 and 21 days; and • improving the proportion of people discharged home using data on discharge to their usual place of residence. We have completed the optional BCF Narrative template, which provides a system strategic overview of the BCF plan, including how BCF programme areas align to wider commissioning, our priorities for 21/22 and our approach to integration. The narrative highlights the continued work to review the BCF plan in the context of developing a Joint Commissioning strategy and workplan and the wider Integrated Care System and Place-Based Partnerships developments. The BCF Planning requirements 2021/22 were

	released on 30 September 2021. Following sign-off by Amanda Sullivan, Mel Barrett and Catherine Underwood, the Better Care Fund 2021/22 Planning Template has been submitted on 17 November 2021.
Is any of the report exempt from publication?	☐Yes ☒No
Is this an Executive decision?	☒Yes ☐No

Recommendation to the Health and Wellbeing Board: Commissioning Sub-Committee:

The Health and Wellbeing Board: Commissioning Sub-Committee is asked to approve the Better Care Fund Planning Template 2021/22 and Better Care Fund Narrative Plan.

Contribution to Joint Health and Wellbeing Strategy:

Health and Wellbeing Strategy aims and outcomes	**Summary of contribution to the Strategy**
Aim: To increase healthy life expectancy in Nottingham and make us one of the healthiest big cities.	**The 2021/22 BCF Plan** The key objectives continue to be: • remove false divides between physical, psychological and social needs; • focus on the whole person, not the condition; • support citizens to thrive, creating independence - not dependence; • services tailored to need - hospital will be a place of choice, not a default; • not incur delays, people will be in the best place to meet their need; and • the vision is that in five years' time care is integrated so that the citizen has no visibility of the organisations / different parts of the system delivering it. The aspiration is that: • people will live longer, be more independent and have better quality lives, remaining at home for as long as
Aim: To reduce inequalities in health by targeting the neighbourhoods with the lowest levels of healthy life expectancy.	
Outcome 1: Children and adults in Nottingham adopt and maintain healthy lifestyles.	
Outcome 2: Children and adults in Nottingham will have positive mental wellbeing and those with long-term mental health problems will have good physical health.	
Outcome 3: There will be a healthy culture in Nottingham in which citizens are supported and empowered to live healthy lives and manage ill health well.	
Outcome 4: Nottingham's environment	

will be sustainable – supporting and enabling its citizens to have good health and wellbeing.	possible; • people will only be in hospital if that is the best place – not because there is nowhere else to go; • services in the community will allow patients to be rapidly discharged from hospital; • new technologies will help people to self-care; • the workforce will be trained to offer more flexible care; and • people will understand and access the right services in the right place at the right time. The 2021/22 BCF plan will continue to build on past achievements in joint prioritisation of resources, avoidance of duplication, flexibility across organisational boundaries and targeting investment to meet shared priorities by taking a whole system perspective. This will be strengthened by work to establish a Joint Commissioning Strategy and workplan and by the continued growth of Place-Based Partnerships.

How mental health and wellbeing is being championed in line with the Board's aspiration to give equal value to mental and physical health
Health and wellbeing will need to be a core element of a truly integrated care model. Leadership to this agenda is provided by the Mental Health and Wellbeing Steering Group and consideration to giving equal value to mental and physical health is embedded within individual schemes.

Reason for the decision:	Formal agreement from the Health and Wellbeing Board is required for the Better Care Fund Planning Template 2021/22 and Narrative Plan.
Total value of the decision:	£44,939,764
Financial implications and comments:	There is minimal financial changes as a result of the plan, schemes and commissioning are largely a continuation of the previous years.

Procurement implications and comments (including, where relevant, social value implications):	Not applicable.
Other implications and comments, including legal, risk management, crime and disorder:	Not applicable.
Equalities implications and comments:	Equality Impact Assessments are completed by the appropriate commissioning organisations as part of the implementation of new services or significant changes to existing services.
Published documents referred to in the report:	NHS England » Better Care Fund planning requirements 2021-22
Background papers relied upon in writing the report:	NHS England » Better Care Fund planning requirements 2021-22
Other options considered and rejected:	Not applicable.

Better Care Fund 2021-22 Template

2. Cover

HM Government

NHS

Version 1.0

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
- 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:	Sarah Fleming
E-mail:	sarah.fleming1@nhs.net
Contact number:	07834 171833

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Sarah Fleming
Name:	Head of Joint Commissioning

Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Wed 24/11/2021

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cll	Eunice	Campbell-Clark	eunice.campbell@nottinghamcity.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Amanda	Sullivan	amanda.sullivan7@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers	N/A	N/A	N/A	N/A@.com
	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		Sarah	Fleming	sarah.fleming1@nhs.net
	LA Section 151 Officer		Clive	Heaphy	clive.heaphy@nottinghamcity.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->	Director of Commissioning and Procurement		Katy	Ball	katy.ball@nottinghamcity.gov.uk

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

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.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Nottingham

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,768,450	£2,768,450	£0
Minimum CCG Contribution	£26,056,676	£26,056,676	£0
iBCF	£16,114,638	£16,114,638	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£44,939,764**	**£44,939,764**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£7,404,568
Planned spend	£10,910,980

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£14,131,830
Planned spend	£14,131,830

Scheme Types

Assistive Technologies and Equipment	£469,180	(1.0%)	
Care Act Implementation Related Duties	£0	(0.0%)	
Carers Services	£714,040	(1.6%)	
Community Based Schemes	£0	(0.0%)	
DFG Related Schemes	£2,768,450	(6.2%)	
Enablers for Integration	£28,036	(0.1%)	
High Impact Change Model for Managing Transfer of	£989,948	(2.2%)	
Home Care or Domiciliary Care	£7,368,530	(16.4%)	
Housing Related Schemes	£85,515	(0.2%)	
Integrated Care Planning and Navigation	£13,711,170	(30.5%)	
Bed based intermediate Care Services	£0	(0.0%)	
Reablement in a persons own home	£0	(0.0%)	
Personalised Budgeting and Commissioning	£0	(0.0%)	
Personalised Care at Home	£0	(0.0%)	
Prevention / Early Intervention	£2,690,257	(6.0%)	
Residential Placements	£0	(0.0%)	
Other	£16,114,638	(35.9%)	!!! Please try to keep 'Other' t
Total	**£44,939,764**		

Metrics >>

Avoidable admissions

20-21 Actual	21-22 Plan

Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	785.0	1,150.0

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more	LOS 14+	9.5%	9.0%
ii) 21 days or more As a percentage of all inpatients	LOS 21+	4.7%	4.5%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	93.0%

Residential Admissions

		20-21 Actual	21-22 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	555	722

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	73.1%

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: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes

Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Nottingham

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

iBCF Contribution	Contribution
Nottingham	£16,114,638
Total iBCF Contribution	**£16,114,638**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

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

CCG Minimum Contribution	Contribution
NHS Nottingham City CCG	£26,056,676
Total Minimum CCG Contribution	**£26,056,676**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£26,056,676**	

	2021-22
Total BCF Pooled Budget	**£44,939,764**

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

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Nottingham

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,768,450	£2,768,450	£0
Minimum CCG Contribution	£26,056,676	£26,056,676	£0
iBCF	£16,114,638	£16,114,638	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£44,939,764**	**£44,939,764**	**£0**

Please note:

Scheme Types categorised as 'Other' currently account for approx. 36% of the planned expenditure from the Mandatory Minimum. In order to reduce reporting ambiguity, we encourage limiting this to 5% if possible.
While this may be difficult to avoid sometimes, we advise speaking to your respective Better Care Manager for further guidance.

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£7,404,568	£10,910,980	£0
Adult Social Care services spend from the minimum CCG allocations	£14,131,830	£14,131,830	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Access & Navigation	Care coordination	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£974,855	Existing
2	Access & Navigation	Single Point of Access	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,061,063	Existing
3	Integrated Care	Integrated care teams covering all subtypes of integrated care planning	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£6,485,015	Existing
4	Integrated Care	Homecare Packages plus integrated team costs	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	Minimum CCG Contribution	£7,368,530	Existing
5	Integrated Care	Care navigation and planning	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		LA			Local Authority	Minimum CCG Contribution	£477,948	Existing
6	Integrated Care	Reablement / Rehabilitation Services	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum CCG Contribution	£3,099,052	Existing
7	Primary Care	Physical Health & Wellbeing	Prevention / Early Intervention	Other	Physical Health & Wellbeing	Primary Care		CCG			NHS Community Provider	Minimum CCG Contribution	£2,690,257	Existing

8	Facilitating Discharge	Integrated enablement teams supporting discharge	High Impact Change Model for Managing Transfer	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum CCG Contribution	£989,948	Existing
9	Facilitating Discharge	Mental Health teams	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,613,237	Existing
10	Programme Management	Programme Management	Enablers for Integration	Integrated models of provision		Other	Programme Management	CCG			CCG	Minimum CCG Contribution	£28,036	Existing
11	Assitive Technology	Telecare, Telehealth & Integrated jointly commissioned response	Assistive Technologies and Equipment	Telecare		Community Health		Joint	46.0%	54.0%	Local Authority	Minimum CCG Contribution	£334,400	Existing
12	Assitive Technology	Dispersed Alarm Service	Assistive Technologies and Equipment	Community based equipment		Community Health		Joint	46.0%	54.0%	Local Authority	Minimum CCG Contribution	£115,900	Existing
13	Assitive Technology	Assistive Tecnology Equipment	Assistive Technologies and Equipment	Community based equipment		Community Health		CCG			Private Sector	Minimum CCG Contribution	£18,880	Existing
14	Carers	Carers Advice and Support & Respite Service	Carers Services	Respite services		Community Health		Joint	59.0%	41.0%	Private Sector	Minimum CCG Contribution	£714,040	Existing
15	Housing Health	Advice & support	Housing Related Schemes			Community Health		CCG			Local Authority	Minimum CCG Contribution	£85,515	Existing
16	Disabled Facilities Grant	Adaptations, community equipment & assistive technology	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£2,768,450	Existing
17	Improved Better Care Fund	Stabilise care provider market, social care reablement & early intervention OT, Citizen Triage	Other		Stabilise care provider market, social care reablement & early intervention OT, Citizen Triage	Social Care		LA			Local Authority	iBCF	£16,114,638	Existing

2021-22 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. 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. Carer advice and support 2. Independent Mental Health Advocacy 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 CCG minimum contribution to the BCF.
3	Carers Services	1. Respite services 2. 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 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 shoukld 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 - including small adaptations 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. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. 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. Domiciliary care workforce development 4. 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	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. 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. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.

12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	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.
15	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.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 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.
17	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.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Nottingham

8.1 Avoidable admissions

		19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only		785.0	1,150.0	The impact of Covid in 20-21 led to a reduction in the overall number of emergency admissions. The plan for 21-22 is for a reduction to the 19-20 position with a focus on population health management principles in looking at place and including both health and social care factors.	**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments	
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	9.5%	9.0%	The ICS are committed to improving the discharge to assess process. This will lead to fewer delays for transfers / discharges between hospital beds to home care and community services. This improvement in process will be complimented by an increase in pathway 1 (care at home) capacity in the system to help reduce the number of people on the Medically Safe For Transfer (MSFT) list. Please see narrative template for further information.	**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**
	Proportion of inpatients resident for 21 days or more	4.7%	4.5%		

8.3 Discharge to normal place of residence

	21-22 Plan	Comments	
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)	93.0%	The discharge to assess approach in the ICS is committed to a 'Home First' principle. Additional capacity is being provided in community health and social care to support the 'Home First' principle and increase the percentage of people returning to their normal place of residence.	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
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	982	1,055	555	722	This data has been extrapolated based on useage over the last 7-months. However, given the current crisis in the home care market and the challenges in the acute, along with the unknown impact of COVID on the NHS it may be result in a higher than usual use of residential.
	Numerator	380	409	217	287	
	Denominator	38,706	38,779	39,125	39,754	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

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

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.0%	88.9%	73.1%	Adult Social Care changed the way in which this data was recorded during the 2020/21 period, which as resulted in a reduced proportion of people still at home and an increase in those who could not be traced and therefore have an unknown outcome status.
	Numerator	724	152	621	
	Denominator	905	171	849	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Nottingham

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes			
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes	BCF Plan Narrative Template		
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	BCF Plan Narrative Template		
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes	BCF Plan Narrative Template		

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes			

Cover

1. Health and Wellbeing Board(s)

Nottingham City and Nottinghamshire County

2. Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

The BCF plan reflects the Nottingham and Nottinghamshire ICS's approach to out of hospital care.

This is based on a number of strategies and approaches that have been agreed by system partners including, but not limited to:

- **ICS Outcomes Framework** that sets out the ambitions we wish to achieve for our population and provides a focus for our collective transformation efforts against the triple aim of improving the health and wellbeing of our citizens, as well as inequalities and wider determinants of health.
- **Clinical and Community Services Strategies**: system partners have developed 20 strategies covering a range of population needs including frailty, heart health, diabetes and CVD to stroke.
- **Population Health Management** Six Step Approach designed to ensure a shared understanding of the needs of our population, enabling focus and resources to be tailored to areas where maximum impact can be achieved.
- **Health Inequalities Strategy**: establishes a shared commitment and vision for addressing health inequalities across the health and care system.
- System **Digital, Analytics and IT Strategy** that identifies the key initiatives that will support service transformation to improve population outcomes including public facing digital services, and a single summary health and care record and supported workflows.
- **People and Culture Strategy**: focused on taking a "one workforce" approach across the ICS, including OD for new ways of working as an ICS.

Our BCF plan is a subset of broader system plans. The development of all these has involved NHS and social care providers, with system governance in place to monitor delivery.

Discharge plans and metrics have been agreed with the relevant acute trusts.

We have four Place Based Partnerships within the ICS which lead delivery of integrated services at a local level: Bassetlaw, Mid Notts, Nottingham City and South Notts. District and Borough Councils are key partners in the County place-based partnerships, recognising their role in the broader determinants of health.

There is also strong VCS engagement in these partnerships ensuring their expertise in understanding communities support delivery at a local level. There has been focused VCS involvement in the Discharge to Assess pathway review.

3. Executive Summary

Priorities for 2021-22

The priorities for 2021-22 build on our progress to date, as well as ensuring a robust response to the Covid-19 pandemic 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.

Through the COVID pandemic we have worked in a more integrated way and are aware of the greater opportunities for future ways of working. The Local Resilience Forum structures developed during the pandemic supported effective partnership working and the decision has been made to maintain many of these structures to aid collaborative working.

Key changes since previous BCF plan

The Nottingham and Nottinghamshire system has continued to evolve, with an ambition to be a high performing Integrated Care System focused on improving health and wellbeing, quality of service provision and achieving effective use of resources.

As part of our development to becoming a statutory ICS from April 2022, we are progressing the integration of social care and health commissioning between Bassetlaw and Nottingham and Nottinghamshire CCGs, Nottingham City Council, and Nottinghamshire County Council.

We have established a Joint Commissioning for Integrated Care workstream that aims to achieve the vision of 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.

We anticipate that our BCF plans will evolve as we develop our joint commissioning approach.

There are a number of key changes in relation to the operational delivery of the BCF in 2021-22:

- **Hospital Discharge:** important progress has been made over the last 9 months because of the way teams have worked together supported by the national discharge funding. Demand and capacity modelling work is now in place to support decision making.

- **Discharge To Assess Pilots: a**s part of the implementation of the new DTA policy, a range of pilots have been implemented and are being evaluated. These include the Home First Rapid Response Pilot in Mid Notts: trialling an approach using additional access and navigation resource in the Integrated Discharge Hub; trusted assessors for pathway 1; additional reablement and care support.

4. Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

Nottingham City

The 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 CCG, with representation including clinical leadership, the City place-based partnership and HealthWatch.

BCF planning, reporting and assurance is undertaken by the Sub-Committee on a monthly basis, or as required.

Nottinghamshire County

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

Officers from the County Council, Bassetlaw CCG and Nottingham and Nottinghamshire CCG have responsibility to ensure appropriate oversight and monitoring.

Partners undertook a review of the BCF governance in 2019, proposing that the BCF Steering Group (which was responsible for the routine monitoring) was replaced by an Integration Board to ensure a focus on integrating health and care commissioning and provision. This proposal was approved by the Health and Wellbeing Board in December 2020.

However, due to the on-going need to respond to the pandemic, the Integration Board was not established. It was agreed in August 2021 that the Board would not be established but that the broader work to develop a Joint Commissioning approach would be allowed to continue to ensure the most appropriate governance is established. In the interim there is a quarterly oversight meeting comprising of senior officer from all key partners and all submissions and proposals received HWBB ratification.

Assurance of the services and projects that make up the BCF plans are undertaken by the relevant system Programme Boards e.g. A&E Delivery Board.

Development of Plan and Sign-off by Health and Wellbeing Boards

The plans have been developed by Bassetlaw CCG, Nottingham and Nottinghamshire CCG, Nottingham City Council and Nottinghamshire County Council. Formal sign off will be undertaken as follows:

Nottingham City: Health and Wellbeing Board sub-committee – 24th November 2021

Nottinghamshire County: Health and Wellbeing Board – 12th January 2022.

5. Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21

Joint priorities for 2021-22

There are a number of transformation programmes that have been established during 2021-22 which support delivery of the BCF objectives. These are multi-year programmes, meaning that some of the benefits will be realised in future years.

Community Care Transformation Programme: a joint health and care programme to deliver a sustainable model of community care provision that aims to optimize people's independence by addressing physical and mental health and social needs, working with communities at a neighbourhood level.

The programme focusses on place-based redesign of community services and develops greater integration between health and non-health services. Through co-production with citizens, staff, partners and stakeholders, the Programme will develop an approach focused on:

- The alignment of health and social care resources and workforce to implement neighbourhood/place-based Community Teams, delivering a consistent model of care across the ICS whilst ensuring services are responsive to local population need.
- Levels of support and care are driven by population health data and intelligence, with a focus on delivering outcomes that reduce inequalities in health and wellbeing.
- Personal and community assets are fully utilised and developed to support outcomes, using a practice framework for an integrated health and social care personalised, strengths and asset-based approach that empowers individuals and communities to take control of their own health and care.
- An organisational development approach for all community care staff to empower practitioners and to support the implementation of the new care model, irrespective of employing organisation and role.
- Adopt a transparent approach across commissioners and providers to ensure we deliver best value for money, moderating costs of care and maximising value (the relationship between quality, outcomes and resources).

The Programme has developed a design framework (referred to as the 'blueprint') for community services based on stakeholder engagement, and an evidence review of local, national and international practice. The blueprint includes core features and the environment to allow improved delivery of community services upon service redesign. The detailed service redesign commences in January 2022.

Ageing Well Programme: a jointly appointed Programme Director is in post, ensuring local alignment with national programme ambitions to:

- Promote a multidisciplinary team approach to provide tailored support that helps people live well and independently at home for longer
- Give people more say about the care and support they receive
- Offer more support for people who look after family members, partners or friends because of their illness, frailty or disability
- Develop more rapid community response teams, to support older people with health issues before they need hospital treatment and help those leaving hospital to return and recover at home
- Offer more NHS support in care homes including making sure there are strong links between care homes, local general practices and community services.

Carers Strategy

A system Carers Strategy Board is developing a carers strategy across the ICS to focus on the needs of our unpaid carers who we recognise have been particularly impacted by the COVID-19 pandemic. The focus is on a developing a single service offer across the ICS that supports the identification of carers, access into advice, assessment, signposting and pre-eligibility carers respite.

As well as key transformation programmes, other key developments are supporting delivery of the BCF plan:

Place Based Partnerships

Our four place-based partnerships (Bassetlaw, Mid Nottinghamshire, South Nottinghamshire and Nottingham City) are ensuring a focus on partners working together at an operational delivery level to develop and deliver community-facing integrated care, joining up community services across sectors and working with community leaders.

This includes supporting the development of Primary Care Networks who are key in delivering our out-of-hospital care.

Quality and Market Management: we are developing an integrated approach across the CCG and County Council to ensure providers are supported and developed to deliver high quality, integrated services.

Approaches to Joint/Collaborative Commissioning

Nottingham and Nottinghamshire ICS are working with the national Better Care Fund team to progress our ambition to develop an integrated commissioning approach that will achieve:

- better outcomes for our residents
- improve access and user experience
- integrated care through provider collaboration
- reduce health inequalities through a greater focus on prevention and early intervention.

A package of facilitation support has been designed with the Local Government Association (LGA) and Institute for Public Care (IPC) to consider local ambitions for joint commissioning, how the system needs to change to meet these ambitions and the priorities that the system will focus on.

A task and finish group has been established consisting of commissioning leads from the CCG and both Local Authorities to:

- Agree a Local Authority and CCG joint commissioning strategy and policy framework to support progress with integrated commissioning and service re-design
- Establish the governance arrangements to support the integration of health and care commissioning and delivery in Nottingham and Nottinghamshire
- Confirm a work programme based on ICS priorities for service delivery areas where there are clear opportunities to improve value through an integrated commissioning approach.

The potential scope of our future joint commissioning is shown below, recognising the breadth of opportunities to improve outcomes for our population through a greater level of integration. This is supported by opportunities in education, environment, leisure, transport, market management and partner roles as anchor organisations in our communities.

Our key areas of focus are:

- Engagement with system partners on the vision for joint strategic commissioning
- Agreement of a joint commissioning strategy and policy framework
- Establishment of a work programme of areas where there is most benefit to be achieved through a joint integrated commissioning approach
- Development and agreement of an appropriate governance and accountability framework that enables joint decision-making, while maintaining compliance with existing legislation
- Identification of capability and capacity within partner organisations to deliver the work programme within the joint strategic commissioning function.

The outputs from the support will shape the ICS's next steps to achieve the vision of Integrated Health and Care, 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.

We expect joint commissioning to evolve on an iterative basis taking into account the development of our Place Based Partnerships and the role of the Health and Wellbeing Boards within our system. As part of this programme we will be reviewing our approach to the BCF and how we collectively invest in services, considering alignment across City and County where appropriate.

Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care

Our approach to person-centred care is underpinned by a developing system approach to coproduction, using expertise across our health, social care and voluntary sector partners.

During 2021-22 an ICS Co-production strategy is being developed that will establish coproduction standards across the whole ICS, and to ensure both staff and people with lived experience have access to the tools needed to coproduce effectively in an equal and reciprocal partnership.

This approach will embed coproduction in all work across the Nottingham and Nottinghamshire ICS as a move towards co-production being the default position including transformational activity, commissioning activity, service/system redesign and quality improvement.

The County Council are embedding strength-based practice using the Three Conversations. They have commissioned a strategic partner, Partners 4 Change to support them to do this and they have established sites of innovation to develop their practice. It is built on the assumption that if you collaborate with and allow people to be co-designers of their support then their positive outcomes go up, and their use of health and social care resources goes down.

How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

The BCF funds a range of services aimed at supporting people to live independently in the community that recognises there is a need to provide integrated services to improve outcomes.

Our approach to integration recognises there are different levels at which integration needs to happen: at both the ICS system level, and within our places recognising the needs of local communities. Our County plan reflects the places of Bassetlaw, South Notts and Mid Notts.

The table below summarises key BCF funded services that are integral to our integration approach.

Nottingham City HWB	**Nottinghamshire County HWB**
Description: There is a continued focus on providing co-ordinated care for our residents, recognising that early access to services and support are critical in supporting people to live independently. This includes our local approach to social prescribing which has developed in light of PCN development and is supporting people to engage with their communities, recognising the assets within our communities.	
Scheme name: Access and Navigation Includes the Health and Care Point that supports self-referral and health and care professional referrals to community services, signposting to services best able to meet people's needs within their communities.	**Scheme name:** **C. Reducing non-elective admissions – Integrated Care Planning and Navigation** **F. Proactive Care – Care Planning, Assessment and Review**

Care Navigators are based within Primary Care Networks, having a geographical focus that ensures an understanding of the assets within a person's own community.	Care Navigators are based within Primary Care Networks, having a geographical focus that ensures an understanding of the assets within a person's own community. Care Co-ordination services are an integral part of the delivery of MDT meetings and working within PCNs. Their role includes the identification of patients that may require a health or social care intervention or in complex cases an MDT discussion. The function is a mechanism for early identification of care gaps resulting in interventions much earlier in the patient's journey.
Description: Health and social care teams adopt an integrated approach to ensure that our residents needs are addressed in a holistic way, supporting people to live independently in their own homes, and supporting people to be discharged from hospital in a timely way, with the aim of people returning to their normal place of residence.	
Scheme name: Integrated Care Includes integrated specialist short term care and rehabilitation within the community to prevent unnecessary hospital admission in a crisis situation and enable citizens to regain their independence and to recover from an acute illness requiring a hospital stay, condition or life event. Integrated Discharge Teams work within hospital settings to ensure appropriate support is identified to avoid and admission in ED / assessment units, and to support effective and timely discharge planning for people admitted to hospital. Community beds are commissioned across City and County, working flexibly so support discharge from hospital, but also providing a geographical focus to support people to remain within their communities.	**Scheme name:** **A. Seven day working: Reablement / Rehabilitation** **B. Delayed Transfers of Care: Multi-disciplinary community teams** **C. Reducing non-elective admissions: Multi-disciplinary community teams and geriatrician input** **K. Discharge / Assessment including intermediate care: care planning, assessment and review** Community geriatricians work within a multi-disciplinary team to support frail older people, proactively to avoid hospital admission, and to support people to maintain independence on discharge from hospital. Integrated Discharge Teams work within hospital settings to ensure appropriate support is identified to avoid and admission in ED / assessment units, and to support effective and timely discharge planning for people admitted to hospital. Community beds are commissioned across City and County, working flexibly to support discharge from hospital, but also providing a

	geographical focus to support people to remain within their communities.
Description: GP practices provide services to support the management of long term conditions aimed at supporting people to live as independently as possible and avoid unnecessary hospital admissions.	
Scheme name: Primary Care Enhanced services for GP practices to support proactive care management of long term conditions. This includes services aimed at supporting our most vulnerable citizens e.g. POW Nottingham which provides outreach services to sex workers in light of the barriers sex workers face in accessing mainstream services.	**Scheme name: C. Reducing non-elective admissions: Integrated Care Planning and Navigation** Enhanced services for GP practices to support proactive care management of long term conditions.
Description: Carers are recognised as a key group to be considered for targeted health inclusion and are recognised as a disadvantaged group. It is recognised that there have been increased pressures on Carers during the pandemic who have faced barriers in accessing care and support and report an increased psychological strain from their caring role.	
Scheme name: Carers Partners jointly commission a carers service that includes the provision of a Carers Hub, Carers breaks and Young Carers support.	**Scheme name:** **L. Respite services** **O. Support for Carers** A Carers Hub provides advice and support with access to formal Carers Assessments, support planning and respite support.
Description: Housing is recognised as a key determinant of health outcomes across the UK, and access to suitable housing which is adapted or adaptable is a significant enabler of work to reduce health inequalities.	
Scheme name: **Assistive Technology** **Housing Health** The role of Assistive Technology in supporting people to live independently. There are a number of offers in place including telecare services and the dispersed alarm service. A Hospital to Home scheme is commissioned from Nottingham City Homes. The service works alongside health and social care providers to assess appropriate patients in a range of settings, including but not limited to patients' homes, Nottingham University	N/A

Hospital sites and mental health inpatient and step down facilities. This supports people to move into more suitable properties in a timely manner, enabling recovery and reablement at home, supporting Discharge to Assess and minimising the clinical risks sometimes associated with delays in transfer of care.	

Please note: specific lines within the BCF planning template may have different names in City and County for similar services due to previous commissioning arrangements.

6. **Supporting Discharge (national condition four)**

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

There is a system Discharge to Assess (D2A) planning and commissioning group responsible for the delivery of effective hospital discharge.

The system vision is:

"Home First for all, with the individual at the centre, starting with the premise that home is the preferred place of care. People are holistically assessed at the right time, in the right place, outside of an acute setting to maximise their independence and improve outcomes by removing traditional organisational boundaries".

Key areas of focus are:

- Ensuring that more of our citizens are discharged home on pathway 0 and 1
- Commissioning of wrap around discharge services which support individuals to be assessed and reabled in the most appropriate environment for their needs including:
    1. Integrated Discharge Teams
    2. Integrated Discharge Hubs
    3. Wrap around services for pathway 1
    4. Pathway 2 and 3 services
    5. An appropriate workforce model
    6. Third sector services
- Home and bed based re-ablement services including wrap around intensive support
- Community referrals into reablement services
- Adequate domiciliary care to further promote Home First principles

BCF funded schemes supporting discharge are detailed in the table on pages 8 to 11 above.

Nottingham University Hospitals – specific actions

Targeted work is being undertaken at Nottingham University Hospitals (NUH) focused on admission avoidance, flow, managing length of stay and discharge from hospital. This is within the context of ongoing system workforce challenges including lack of capacity in the home care market, adult social care and community health care workforce, recognising this is a challenge nationally. This impacts on discharges from hospital and the number of 14/21 LOS patients who are medically safe for discharge has seen an increase.

The following **NHSE/I Nottingham System and ECIST Concordat priorities** have been agreed as of 1st November 2021:

- Improving Specialty Collaboration to decrease patient waits and improve flow
- Improve Primary Care and UTC collaboration to improve admissions avoidance and diversion
- Enhance/develop ED avoidance by transfer to virtual wards or SDEC

- Improve the quality and safety of streaming and initial assessment in ED
- Further reduce length of stay pre-medically fit for transfer
- Further develop D2A for the short, medium and long term – restating the system's shared purpose is to transfer patients out of hospital within 24 hours of being medically fit for transfer.

A **Supporting Best Practice for Board/Ward Rounds Rapid Improvement Event** started week commencing 1st November 2021. The focus was on:

- Collaboration with NHSE/I through the Alliance 16 Programme and NUH clinical colleagues
- Aim for board/ward rounds to provide the framework for effective discharge planning giving opportunity to:
    - bring together the good practice currently being delivered in the NHS and enabling compliancy with national policy (Reasons and no reason to reside codes, using criteria led discharge (CLD) to ensure timely and effective discharge, escalation of delays and afternoon huddles to promote accurate planned date medically safe (PDMS) and a forum to ensure jobs are completed on time to reduce delayed/failed discharges)
    - take the learning from the NUH improvement PDSA cycles and 'Always Events' for improving discharge to further encourage "getting it right first time" (GIRFT) and planning tomorrow's work today principles
    - enable clinical teams to self-assess against good practice and identify priorities for improvement
    - offer organisational leaders a template for a standardised approach to multidisciplinary team inpatient assessment, which can be delivered through hospital-wide improvement programmes that enable a drive for reliability and a drive to reduce unwarranted variation
    - describe how care can be delivered in hospital in partnership with patients, families and carers
    - reiterate and update the guidance published in Ward rounds in medicine: principles for best practice (2012). While that guidance was welcomed, it has not been widely implemented.

This approach will initially be focused on four cohorts working over 32 wards over a 12 week period. This approach ensures that the wards that more directly impact ED success are included and would therefore expect to see an impact on hospital flow sooner.

Local Government Association Peer Review

The ICS is participating in a Better Care Peer Led System Review of Discharge to Assess, a sector-led, constructive and supportive process based on the foundation of supporting continuous improvement.

A peer-led whole system review took place on 9th November 2021, with attendance from across the system from health, social care, and voluntary sector system partners including patient representation via Healthwatch and Nottinghamshire Hospice.

A Discharge Policy Gap Analysis Survey designed to identify the key elements of the Discharge Policy which need urgent attention for implementation, drawn from the views of all staff, across the

system and community partners has taken place. A workshop is to take place shortly, to identify and structure the priorities and issues into an action plan and collectively agree the next steps.

Supporting Additional Discharge Capacity for NUH

The System Planning Group and Capacity Cell's jointly led modelling work has identified a number of service improvement and capacity actions. A plan has been developed collaboratively with providers with challenge and confirmation across system groups, using agreed planning assumptions. The plan will be refined and iterated as the system position changes throughout winter.

There are daily meetings to support discharge planning for people who are Medically Safe for Transfer, and the reasons for delay themes are captured, investigated and followed up.

Nottingham City Council has commissioned two pilots to provide a bridging service, which supports improved flow through the Nottingham City D2A system and appropriate discharges from hospital into re-ablement:

1. **The TEST team:** The service takes patients from the City LA internal re-ablement service (clinical intervention is OT intervention where indicated to maximise independence) to allow the service to take additional discharges from acute / community settings. The patients have already been through the re-ablement service, so their care needs are lower than when first discharged, allowing a greater number of patients to be supported than if taken directly from acute /community
2. **Additional interim homecare:** Citizens are then discharged to the block service. This service holds citizens for up to 2-weeks which allows the external market to secure a regular package of care in the regular run.

To address the capacity for assessment both in the acute hospital and in the community-based services based on demand and flow NCC is to recruit additional assessment and supervisory capacity in the TEST Team and IDT/IET support to meet demand in allocation for identification of discharge pathway, and long-term assessment.

7. Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people.

Nottingham City Council have produced a draft Housing and Support Strategy Action Plan.

Key Principles: A home that is not just 'good enough' but that actively enables and promotes wellbeing to:

- Support people to live more independently (less restrictive models)
- Focus on preventive approaches to support independence
- Develop solutions with people, providers and the system
- Build on what works well
- Actively shape the market
- Ensure a strong focus on independence

Key Enablers:

- Digital and Technology
- Adaptations, equipment and small aids
- Portable adaptations to enable flexible use of housing
- Housing related/tenancy related support
- Targeted prevention
- Development of creative accommodation and care options

Nottinghamshire County Council has an active programme of DFG delivery working in partnership with the seven district and borough councils to deliver adaptations in people's homes enabling them to be as independent as possible. The DFG programme also supports countywide initiative such as the Warm Homes on Prescriptions and the Handy Person Adaption Service.

Currently the countywide DFG Partnership has been developing a DFG Policy which has been or is in the process of being adapted by each district or borough council. This policy supports the DFG delivery and provides guidance to ensure that there is a collective approach to DFG delivery. The policy will be supported by an MOU that clarifies the relationship between the County Council and the District and Borough Councils identifying respective responsibilities with the overarching aim of ensuring that the adaption meets an individual's need and allows the individual to live a healthy and independent as possible life in a place that they can call home.

Nottinghamshire County Council transfers the full DFG value to the District and Borough Councils, with the exception of the funding agreed for the Handy Person Adaptation Service (HPAS) which provides help and support to keep people safe and secure in their home with essential adaptations and small practical jobs.

8. Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

The ICS Health Inequalities Strategy 2020-24 sets out the key objectives for addressing inequalities for people in our system with a focus on:

- Health and care services
- Lifestyle factors
- Living and working conditions.

It is recognised that within Nottingham and Nottinghamshire there is a diverse population and geography with areas of significant deprivation. Covid19 has exacerbated these inequalities. Through the Covid19 vaccination programme considerable efforts have been applied to targeting groups experiencing health inequalities and this has provided extensive learnings in relation to working at place level, taking a culturally competent approach and supporting those most in need. The BCF will continue to reflect the learning at place, ensuring services are designed to address with the needs of those experiencing the greatest inequalities, taking a personalised approach.

Equality Impact Assessments are undertaken when services are reviewed and commissioned. The use of the Public Health England Health Equity Assessment Tool (HEAT) is currently being reviewed as a systematic, continuous improvement framework to assessing the extent to which services and transformation programmes are ensuring health inequalities are being addressed.

BCF services supporting our approach to addressing inequalities include:

- **Carers support:** the ICS is developing a Carers strategy that seeks to develop a single model of support including a carers hub, providing a single point of contact for all Carers to provide advice, assessment and support planning, signposting and a gateway into 'pre-eligibility' Carers' respite ("Short Breaks"). This will provide an early intervention and personalised approach for the provision of support and respite breaks for Carers.

- **POW Nottingham**: a service is commissioned in City to provide outreach services to male and female sex workers in light of the barriers sex workers face in accessing mainstream services. The service supports health and wellbeing needs, recognising that sex workers are at higher risk of poor sexual health, as well as vulnerabilities such as violence, rape and sexual assault, homelessness, and drug and alcohol problems.

- **Hospital to Home (City):** a dedicated housing specialist supports patients who are inappropriately housed, where this is putting them at risk of hospital admission or causing a delay in discharge.

A dashboard is being developed to support the system in understanding inequalities in service use and outcomes. This will be supported by health gain metrics to support prioritisation and demonstrate value in our services.

A learning environment for health inequalities and equity is being created, with workforce development for training on the social determinants of health and understanding the wider context in which our citizens live e.g. housing, education, employment, environment, power and discrimination.

This includes services funded through the BCF and will also support an understanding of inequality of outcomes related to BCF metrics.