Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

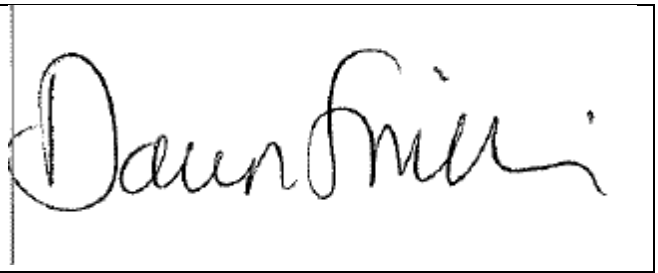
To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

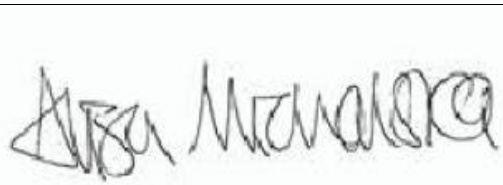
a) Summary of Plan

Local Authority	**Nottingham City Council**
Clinical Commissioning Groups	**NHS Nottingham City**
Boundary Differences	**Boundary is coterminous with the City Council**
Date agreed at Health and Well-Being Board:	**4th April 2014 – Revision approved 18th September 2014**
Date submitted:	**19th September 2014**
Minimum required value of BCF pooled budget: 2014/15	**£7,104 Million**
2015/16	**£21,421 Million**
Total agreed value of pooled budget: 2014/15	**£11,566 Million**
2015/16	**£25,845 Million**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dawn Smith
Position	Chief Officer, NHS Nottingham City CCG
Date	19.09.14

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	
By	Alison Michalska
Position	Corporate Director of Children and Adult Services, Nottingham City Council
Date	19.09.14

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Alex Norris Nottingham City Health & Wellbeing Board
Date	19.09.14

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
01 Integrated Care Programme Plan	Detailed Programme plan describing the new model of integrated care and the projects established to deliver the vision.
02 Health and Wellbeing Strategy	Priority 2 describes Integrated Care and how the Health and Wellbeing Board will monitor outcomes of the planned changes to the health and social care system
03 South Nottinghamshire 5 Year Strategy	Strategic Plan 2014/2015 – 2018/19
04 Draft BCF Benefits Realisation Plan	Maps schemes to outcomes, impacts and metrics
05 BCF Indicator report	Our locally developed format for internal BCF monitoring across the key metrics.
06 Care Bill funding with BCG allocation	Outline of how the BCF will meet Care Bill requirements
07 Consent Form Exemplar	Consent Form- Sharing your personal health record
08 Nottinghamshire Information Sharing Protocol	An overarching framework for partner organisations in Nottingham and Nottinghamshire to manage and share information on a lawful and 'need to know' basis with the purpose of enabling them to meet both their statutory obligations and the needs and expectations of the people they serve.
09 Project timelines	Detailed project plans mapping out the key milestones associated with the delivery of the main BCF schemes as part of our programme of transformation.
10 Connecting Care newsletter	Stakeholder newsletter

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Our vision is to enable people living in Nottingham to live longer, be healthier and have a better quality of life, especially in the communities with the poorest health. We will achieve this by local people, commissioners and providers working together to transform the health and social care system. Our aim is to remove organisational barriers and ensure that teams from different sectors work together seamlessly. Citizens will receive care in their home or the community; by shifting resources from hospitals to primary and community care we will be able to reduce unnecessary hospital admissions and shorten hospital stays. Services will be high quality, accessible, sustainable and based on the real needs of the population.

Nottingham City is a key contributor to the South Notts unit of planning transformation programme which supports delivery of the 2 and 5 year strategy. At a local level we are undertaking an extensive system wide Programme of change (the Integrated Care Programme) which will see local services reshaped to deliver joined up care. The Better Care Fund will be used to fund key service and transformation activity within the Integrated Care Programme.

The Health & Wellbeing Board approved its strategy for Health & Wellbeing in Nottingham in March 2014. Our local vision is to improve the experience of and access to health and social care services for citizens. This is reflected in the Nottingham HWBS 2013-16 key strategic priority to "improve the experience of and access to health and social care services for citizens who are elderly or who have who have long term conditions." The number of citizens remaining independent in the community, including after hospital admission will increase with improved and seamless transfers of care.

The extensive patient and citizen engagement undertaken as part of the 'analyse' phase of the Integrated Adult Care Programme in 2012/3 indicated the following priorities for integration:

- Assessment – information recording and sharing, holistic person centred needs assessment and support planning,
- Access to and navigation of service provision
- Care coordination with a single care coordinator particularly for those with multiple needs;
- Workforce standards and training;
- Funding for care and health needs

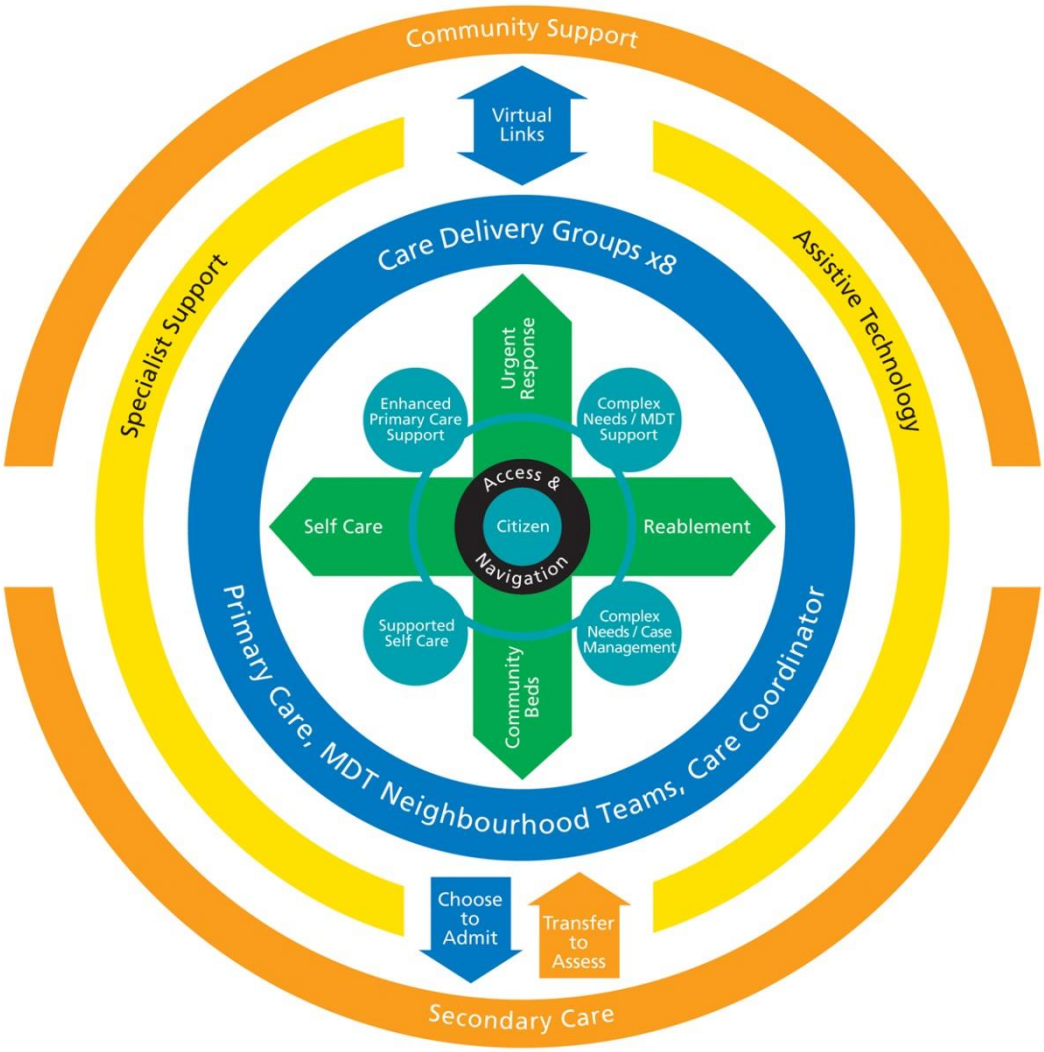
JSNA projections of increasing demand and cost in relation to older citizens and those with long-term conditions - including a 15% rise in the over 85 population by 2020 and 66% hospital bed days occupied by those with long-term conditions – have informed the need for a HWBS priority in this area.

Our integrated care model is a whole system model with the citizen at the centre. It

includes simplified access and navigation, equitable access to reablement, an effective response in a crisis situation and Care Delivery Groups offering a proactive / multi-disciplinary approach including primary care and social care. Links to the community and voluntary sector to ensure on-going support for our citizens will be developed. The model also describes a new relationship with secondary care whereby citizens only go into hospital when they have a medical need that cannot be met in the community and their care is transferred back into the community as soon as they are medically stable.

The emphasis of the new model of integrated care will be on a more generic model of care across the health and social community rather than single-disease specific care pathways. In approaching care in this way we are able to ensure patients are managed in the community more effectively and efficiently, reducing emergency admissions, re-admissions and supporting the discharge pathway. As a result of the programme more citizens will report that their quality of life has improved as a result of integrated health and care services.

In scope of the Integrated Care Programme are the following long term conditions: respiratory conditions, cardio vascular conditions, diabetes, neurological conditions, stroke, dementia, cancer, osteoporosis and the frail elderly (who are likely to have one or more of these conditions but may not present with a medical need as the primary reason for intervention).



This programme of work is now in the second phase with the following already in place:

- *8 Care Delivery Groups incorporating groups of GP practices, multi-disciplinary neighbourhood teams, social care link workers and care coordinators are operational across the city.*
- *Intermediate care services, crisis response and Local Authority reablement and emergency home care services have been reconfigured and processes aligned to support the independence pathway (a new model of social care assessment and rehabilitation)*
- *Assistive technology has been expanded to support an early intervention and proactive approach to care.*

The first phase of the Integrated care programme has been successful and has achieved a much greater understanding of operational processes and improved information sharing across organisations. Further development is underway to embed a multi-disciplinary approach across primary care, community health and social care; this will include supporting the necessary culture change to deliver joined up care.

To realise the benefits of the whole system model transformation is now focused on the following with planned implementation throughout 2014/15.

- *Review of specialist services and integration into neighbourhood teams as appropriate.*
- *Choose to admit / transfer to assess – introducing new services and redesigning services to ensure that citizens only go into hospital with a medical need which cannot be met in the community and that their care is transferred back into the community as soon as they are medically stable.*
- *Seven day working – expansion of community services linked to primary care and secondary care operational delivery plans to enable citizens to remain at home wherever possible.*
- *Integration of Nottingham Health and care point (community health and social care access point) to simplify access to services for citizens.*
- *Further expansion of the assistive technology service*
- *Further development of a joint assessment and care planning approach across health and social care.*
- *Implementation of the self care pathway to support early intervention.*
- *Formalising links with the community and voluntary sector to create a 'pull' from health and social care services.*

An external evaluation of the programme is in place and based upon the learning from this evaluation the scope of the approach will be expanded to include other areas, for example, mental health.

We recognise that to fully achieve our vision by 2019/20 we will benefit from a different approach to commissioning. We are exploring alternative commissioning approaches to support integrated care and improve patient outcomes. Our aim is to introduce an

‘accountable care system’ in line with the re: procurement of community services by April 2016.

Our vision is shaped by, and continues to be shaped by our citizens and our staff. Following detailed engagement citizens have described the following outcomes which we aim to achieve by 2019.

- Access to services will be less complex through single points of access and use of web based information allowing self-access
- People will only tell their story once as assessment functions are joined up and information is shared across health and social care
- Citizens will have greater choice and control over their lives and greater support in self-care.
- People will have greater self-awareness of how to improve their own health and wellbeing through prevention and healthy lifestyles
- Local communities and individuals will be healthier, live longer and more independently. They will be supported to live with risk and will be less reliant on statutory services
- Hospitals and long term care will be last resorts and only when there is an absolute need that cannot be met outside of these environments
- Organisations will be joined up and will work together to share resources and learning

b) What difference will this make to patient and service user outcomes?

An overarching objective of the Integrated Adult Care Programme is to transform citizen experience of Health and Social Care provision in the City. This is encapsulated in the HWBS Vulnerable Older People Priority to “improve the experience of and access to health and social care services for citizens who are elderly or who have who have long term conditions”.

In five years’ time, the aspiration is that:

- People will be living longer, more independent and better quality lives, remaining at home for as long as 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
- Specialist workforce teams will be concentrated in one place
- The workforce will be trained to offer more flexible care
- People will understand and will access the right services in the right place at the right time

The most fundamental changes that citizens will experience will result from the adoption of models of integration that make a person’s journey through the system of care as

simple as possible; and encourage shared decision making.

The patient's perspective will become the key organising principle of service delivery, and they will receive the care that they need, when they need it, driven by their requirements not the capacity/capability of the suppliers.

The ultimate vision in 5 years' time would be for care to be so well integrated that the patient has no visibility of the organisations/different parts of the system delivering it.

The independent evaluation of the Integrated Adult Care Programme will ask the following questions relevant to BCF schemes of: Care Coordination, Independence Pathway, Assistive Technology, Access and Navigation, Carers.

- Do citizens find it easier to access and navigate services?
- Do citizens have improved choice and preservation of independence?
- Do citizens feel services are more joined up?
- Do citizens have improved experiences and satisfaction with services?

This will be developed into our BCF patient experience metric and enable us to measure the benefits realised through the BCF Plan in 2016 and 2019 against the 2014 baseline.

What will be different for Ada and Maureen?

At the start of the Integrated Care Programme we created a short animation called Ada & Maureen. Ada represents the familiar citizen and Maureen represents the familiar carer experience within our current health and social care system.

Ada has a number of health problems and is becoming increasingly frail and more reliant on support. Her daughter Maureen is willing to care for Ada but sometimes struggles to access the advice she needs. Ada is in regular contact with her GP who deals with medical needs as they arise. She is visited by specialist nurses who deal with her diabetes and her heart failure, they sometimes visit on the same day not aware of each other's plans. Ada cannot understand why she is asked the same questions repeatedly and why one nurse can't do tests on behalf of the other nurses.

Ada wants to be as independent as possible and doesn't always ask for help when she needs it. As a result she falls and is admitted to hospital where she is asked the same questions that she has already answered several times whilst at home. Ada becomes increasingly confused whilst in hospital and less able to care for herself, the hospital team are reluctant to discharge Ada home as they are fearful of how she will cope.

Eventually Ada is discharged with the support of a rehabilitation service who work with Ada and Maureen to ensure that Ada is as independent as possible and doing as much for herself as she can. She requires more care than Maureen can manage and the social worker arranges a homecare package; Ada is asked the same questions once again. When Ada's rehabilitation is complete and the care package is in place Ada and Maureen are left alone to cope. As Ada's health deteriorates they struggle to know where to get the help they need to manage the change in Ada's health and care needs. The staff are all very caring and they all appear to do their job well, but do not see Ada as a whole person with a complex set of needs .Maureen becomes exhausted and Ada is admitted

to short term care, she never returns home.

By 2019 the integrated health and care system in Nottingham City will offer Ada and Maureen a very different experience. Ada will be identified as benefiting from support at an early stage through the use of risk profiling. Care Delivery Groups made up of GP practices and MDTs, supported by care coordinators will ensure that Ada receives the right intervention at the right time and that staff are fully informed of Ada's situation.

The multi-disciplinary team will identify a lead professional who will ensure that Ada and Maureen are getting advice and support from the relevant professionals. Ada will only go into hospital when she needs to, as soon as she is medically stable the community will take over her care so that she can return home as quickly as possible, limiting her deterioration in hospital.

Integrated health and social care reablement services will assess Ada and work with her to ensure that she is as independent as possible. When her rehabilitation is complete she will be supported on an ongoing basis. This support might come from the voluntary sector who will have links into the MDTs. Maureen will have her needs assessed to ensure that she is able to continue her carer role.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Integrated services across health and social care will be delivered in a community setting and in citizens homes wherever possible. A renewed focus on early intervention and prevention will ensure that citizen's needs are met at an earlier stage and that they are supported to be as independent as possible for as long as possible.

Coordinated care

Care Delivery Groups (CDGs) will develop to support general practice to work closely with community services and social care to identify citizens who will benefit from intervention before they reach crisis. Support will be well coordinated with all MDT team members, citizens and carers aware of planned interventions.
Citizens who require on-going case management will have a named professional responsible for their care.

Developments in primary care support this new approach to care:

<u>Ensuring tailored care for vulnerable and older people</u>
The service builds on and strengthens the new 'avoiding unplanned admissions enhanced service: proactive case finding and care review for vulnerable people' published April 2014. The service is commissioned to proactively review patients aged 75 or older and patients at risk of an admission/re-admission within a multidisciplinary framework and also engage in further work around this cohort to enhance integration and cross practice links within care delivery groups.

This service will ensure that all patients aged 75 and over and those that are vulnerable and at risk of admission/readmission are proactively reviewed to ensure they have a

comprehensive and co-ordinated package of care. It is anticipated that a proactive review will enable future health needs to be identified early, providing better health outcomes for the patient in the longer term.

Practices, through this service, will be required to:

1. Provide number of patients aged 75 and over and patients at risk of admission or re-admission:
    - List size
    - Number of patients aged 75 and over
    - Number of patients at risk of admission or re-admission (that are **not** aged 75 and over)
    - Number of patients identified for service
2. Hold monthly multi-disciplinary team meetings (MDT) with appropriate neighbourhood team personnel to proactively discuss identified patients aged 75 and over and patients at risk of admission or re-admission, recording outcome for each patient discussed. Practice will use eHealthscope to log the following:
    - Date of meeting
    - Who attended meeting
    - Summary of meeting (i.e. number of patients discussed etc)
3. Implement a template within the clinical system to capture patient information for the identified population. The template is an enhancement to the template developed for the new enhanced service, and aligns to wider working within integrated care teams.

Practices will need to share relevant information with community teams and or care co-ordinators and except feedback from community teams and or care-co-ordinators in respect of the quality of the content or missing information.

4. Proactively obtain consent from patients to share patient information with community teams, thus developing a key foundation for integrated working:
    - SystmOne practices have the functionality to share patient information
    - EMIS practices to share relevant information with community teams and or care co-ordinators, sharing information in the form of paper records or other functionality when available

Practices will report on a quarterly basis the consent status for patients identified for this service:

- Number of patients asked
- Number of patients declined
- Number of patients agreed
- Exemptions (i.e. inappropriate to ask etc)

Practices should aim to have asked 50% of patients by 31 December 2014. By 31 March 2015 75% of patients should have been asked and 100% of patients should have been asked by 30 June 2015 (excluding exemptions).

5. Attend a quarterly care delivery group network event which allows sharing of best

practice across member practices and helps build relationships and working across practices within the care delivery groups. Each practice must have clinical representation, who are active in the MDT, at each event.

The BCF has supported a comprehensive multi-disciplinary approach in CDGs, funding dedicated social workers and care coordinators.

Independence Pathway

The BCF is supporting our joint commissioning approach to the development of reablement services to meet the needs of a wider cohort of citizens and support the choose to admit / transfer to assess model of care at the interface with secondary care.

Transfers of care will be managed through well coordinated services responding to the needs of the citizen, reablement services will be able to flex capacity to meet periods of high demand such as over the winter period. A new model of reablement which supports citizens with a range of support needs from a break down in social care support to complex health interventions will be available to prevent hospital admission as well as facilitate discharge as soon as patients are medically stable. Social care assessment services are being reconfigured to support this new model of reablement.

All services will be supported by a 'pull' from the community and voluntary sector who will offer on-going support for people who no longer require health or social care interventions.

Access and Navigation

Support functions such as coordination services and a fully integrated health and care access point are included in our plan to support us in our aim to provide equitable care based on individual need. The BCF supports the development of these services and the joint approach to planning.

Seven Day Services

Access to care seven days a week. Seven day services will ensure that citizens are supported at home wherever possible. Evidence shows that the limited availability of some services at weekends can have a detrimental impact on patient outcomes, as well as increasing hospital admission rates and delaying discharges. The BCF seven day working schemes will ensure availability of appropriate services as well as ensuring coordination to prevent hospital admission and facilitate timely discharge.

Assistive Technology

Assistive Technology has been included in our plans in recognition of the vital role it has in our early intervention approach. Through the use of the pooled budget we can move forward with a shared understanding that Telehealth and Telecare have benefits for both health and social care in the expansion of the service.

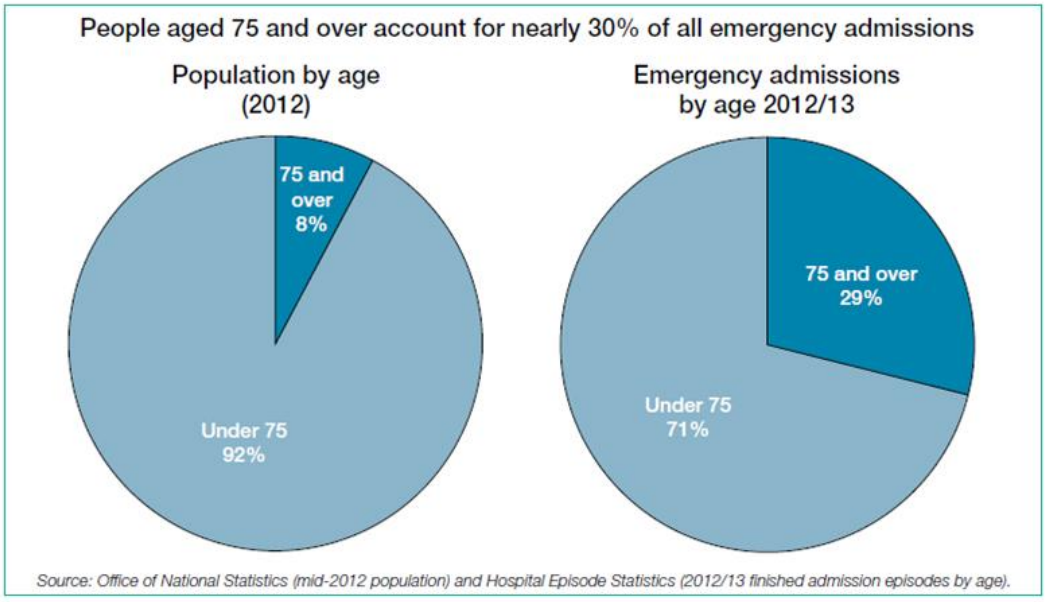
3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

NATIONAL CASE FOR CHANGE

A recent DH publication – *Transforming Primary Care* (April 2014) outlines the changes which need to occur across primary care (including community services) to ensure that care is safe, proactive and personalised for those who need it most. There is a clear need to transform health and care services based on an increasing aging population with more chronic conditions, a system which is reacting to increasing emergency admissions and an increasingly complex health and social care landscape where patients feel their conditions are managed in isolation.

People aged over 75 currently account for nearly 30% of all emergency admissions (Figure.1 below), and by 2024 it is expected that people aged 75 and over will make up more than 10% of the population (Office of National Statistics). Taking into account this increasing ageing population alongside budgetary pressures it is clear to see why there are so many calls nationally for care to be transformed.



The implementation of integrated care has long been established as a key method for reforming health and social care services based on five key national drivers outlined below:

- *Integrated care addresses the changing demand for care*
- *Integrated care recognises that health and social care outcomes are*

interdependent

- *Integrated care is a vehicle towards social integration of society's more vulnerable groups*
- *Integrated care may lead to better system efficiency*
- *Integrated care may improve the quality and continuity of care*

(Wait, European Social Network Conference, Edinburgh 2005).

Transforming Primary Care outlines a clear vision that Better Care Fund plans will support integration of health and social care services. Within the next section we will articulate how at the Health and Wellbeing Board level we consider the case for change locally.

LOCAL CASE FOR CHANGE

The national case for change also applies locally, but can be more specifically described for Nottingham by reviewing the health and social care needs of Nottingham City residents and the complexity of needs identified through risk stratification. Reviewing outcomes of local utilisation reviews, activity/demand modelling and capacity planning has also informed our response to tailoring our BCF plans to meet local needs in Nottingham.

Health and Social Care needs in Nottingham

Population segmentation

Data available from the local JSNA, Public Health teams and Projecting Older People Population Information (POPPI) dataset reveals the following information about our increasingly aging population in Nottingham with a higher prevalence of long term conditions.

- Currently there are 34,800 over 65's living in Nottingham City. Of these 18,165 are thought to have one or more long term condition. (JSNA 2010)
- The number of people aged over 65 is projected to increase by 3100 to 40,000 by the year 2020. (Poppi 2014)
- By 2020, there will be 20% more patients with diabetes, 10% more patients with hypertension, coronary heart disease and COPD, 8% more patients with stroke. (Public Health 2010-11)
- 2,718 local people have dementia in Nottingham- by 2030 the number of people with dementia in Nottingham City will increase by 33 per cent. (Poppi 2014)
- 2,750 people in Nottingham have a cancer diagnosis. This could increase by about one-third by 2020. (Public Health 2010-11)
- Patients with long-term conditions account for 52% of all emergency admissions to Nottingham University Hospitals (14,124), as well as 66% of all bed days (79,565). (Public Health 2010-11)

Risk Stratification

Risk stratification is already in use across the City and we have built upon this process through the Integrated Care programme because we recognise that an accurate predictive risk model identifies those who are most at risk of unplanned admissions in the future (Duncan, 2011). Our process allows multi-disciplinary teams (MDTs) to target

interventions according to need with intensive case management targeted at those most at risk. This is based on the Kaiser Permanente risk stratification pyramid and model for chronic disease management using three key approaches:

- case management for the small minority of patients with highly complex and multiple conditions requiring high-intensity professional support.
- disease management for people with a complex single or multiple conditions who would need to be managed proactively by responsive specialist services
- supported self-care for the majority of those living with – or at high risk of – long-term conditions

Predictive modelling is used to support proactive case management of patients by risk-stratifying a population and identifying patients who may be suitable for intervention. This is completed through the use of the Devon Predicted Model which is hosted in eHealthscope. eHealthScope is a locally developed data integration and processing tool which uses Hospital Episodes Statistics (HES) to calculate risk scores for each patient, reflecting their future risk of admission into hospital. We can then stratify patients according to their risk score and produce an overview of the number of patients in each stratum. This allows for specific patient cohorts to be prioritised for proactive preventative care, with the ultimate aim of improving patient quality and outcomes and the efficient use of resources.

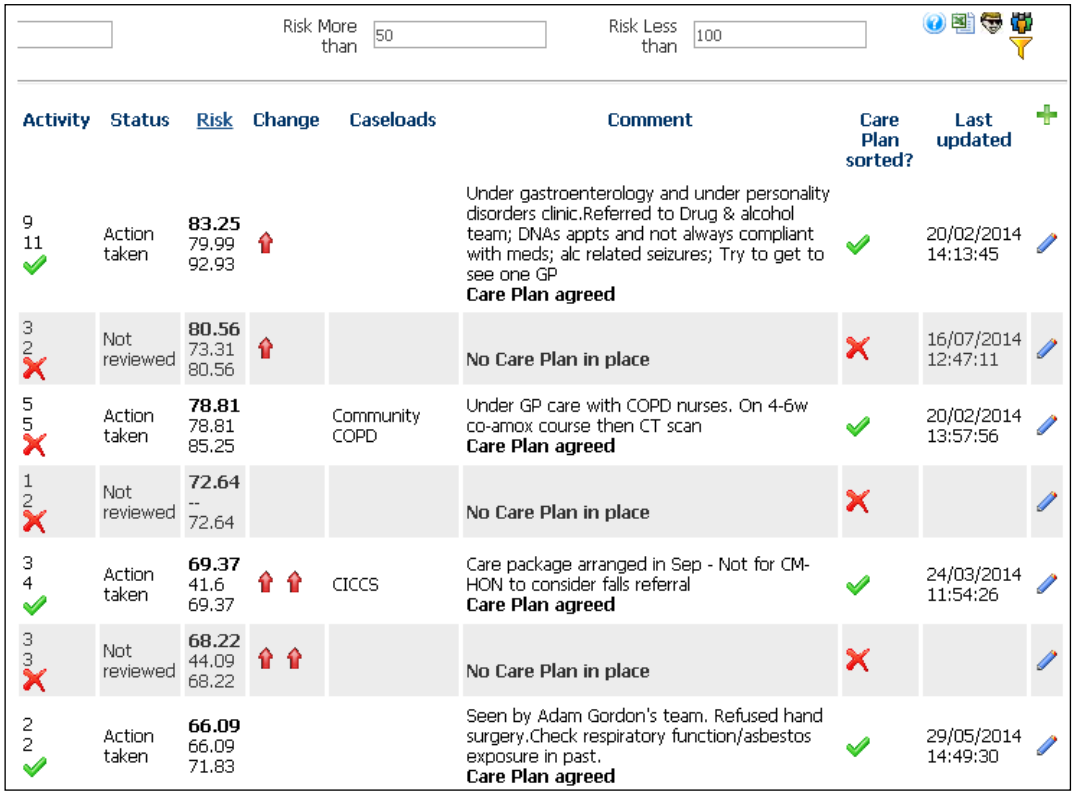
Figure 2. The risk stratification pyramid for Nottingham City, August 2014. (eHealthscope, 17,660 patients eligible for a risk score).

This tells us that in Nottingham out of our GP registered population size of 354,282, 17,660 patients are currently at risk of admission to hospital (4.9%). Of these patients 97 are at very high risk (90-100%) of admission, 230 at high risk (80-90%) and 983 and moderate risk (60-80%).

The risk stratification data is routinely used by multi-disciplinary neighbourhood teams (MDTs) during their monthly MDT meetings to identify and review patients at high risk of

future admission as well as a review of patients on the current case load. The health and social care professionals at the MDTs are then able to plan a co-ordinated package of care in a targeted approach using either case management, disease management or providing supported self-care.

An example of the risk of admission log is below. The log details admissions into hospital, current and previous risk scores and notes any changes that have occurred. It shows at a glance if the patient is being reviewed by a particular team and also comments that were made that will enable better care.



Risk More than 50 Risk Less than 100

Activity	Status	Risk	Change	Caseloads	Comment	Care Plan sorted?	Last updated
9 11	Action taken	**83.25** 79.99 92.93	↑		Under gastroenterology and under personality disorders clinic.Referred to Drug & alcohol team; DNAs appts and not always compliant with meds; alc related seizures; Try to get to see one GP **Care Plan agreed**	✓	20/02/2014 14:13:45
3 2	Not reviewed	**80.56** 73.31 80.56	↑		**No Care Plan in place**	✗	16/07/2014 12:47:11
5 5	Action taken	**78.81** 78.81 85.25		Community COPD	Under GP care with COPD nurses. On 4-6w co-amox course then CT scan **Care Plan agreed**	✓	20/02/2014 13:57:56
1 2	Not reviewed	**72.64** -- 72.64			**No Care Plan in place**	✗	
3 4	Action taken	**69.37** 41.6 69.37	↑ ↑	CICCS	Care package arranged in Sep - Not for CM-HON to consider falls referral **Care Plan agreed**	✓	24/03/2014 11:54:26
3 3	Not reviewed	**68.22** 44.09 68.22	↑ ↑		**No Care Plan in place**	✗	
2 2	Action taken	**66.09** 66.09 71.83			Seen by Adam Gordon's team. Refused hand surgery.Check respiratory function/asbestos exposure in past. **Care Plan agreed**	✓	29/05/2014 14:49:30

Level of unmet need locally

Utilisation Reviews

East Midlands Procurement and Commissioning Transformation (EMPACT) programme completed three utilisation reviews for Nottingham City during 2012 reviewing utilisation of Intermediate Care, Community Health and our acute Trust Nottingham University Hospitals. The key findings are summarised in the Table.1 below.

Table.1 EMPACT Utilisation review summary findings for Nottingham.

Intermediate Care	Community Health	Acute care - NUH
Approximately three quarters (765) of all patients were appropriately admitted to intermediate care services.	43% of patients reviewed no longer met criteria to be in a community hospital at some point during their stay – their care needs could have been meet in other care settings, most commonly in home or home care settings. This represents 862	22% of admissions were inappropriate and should have been admitted to alternative locations of care.

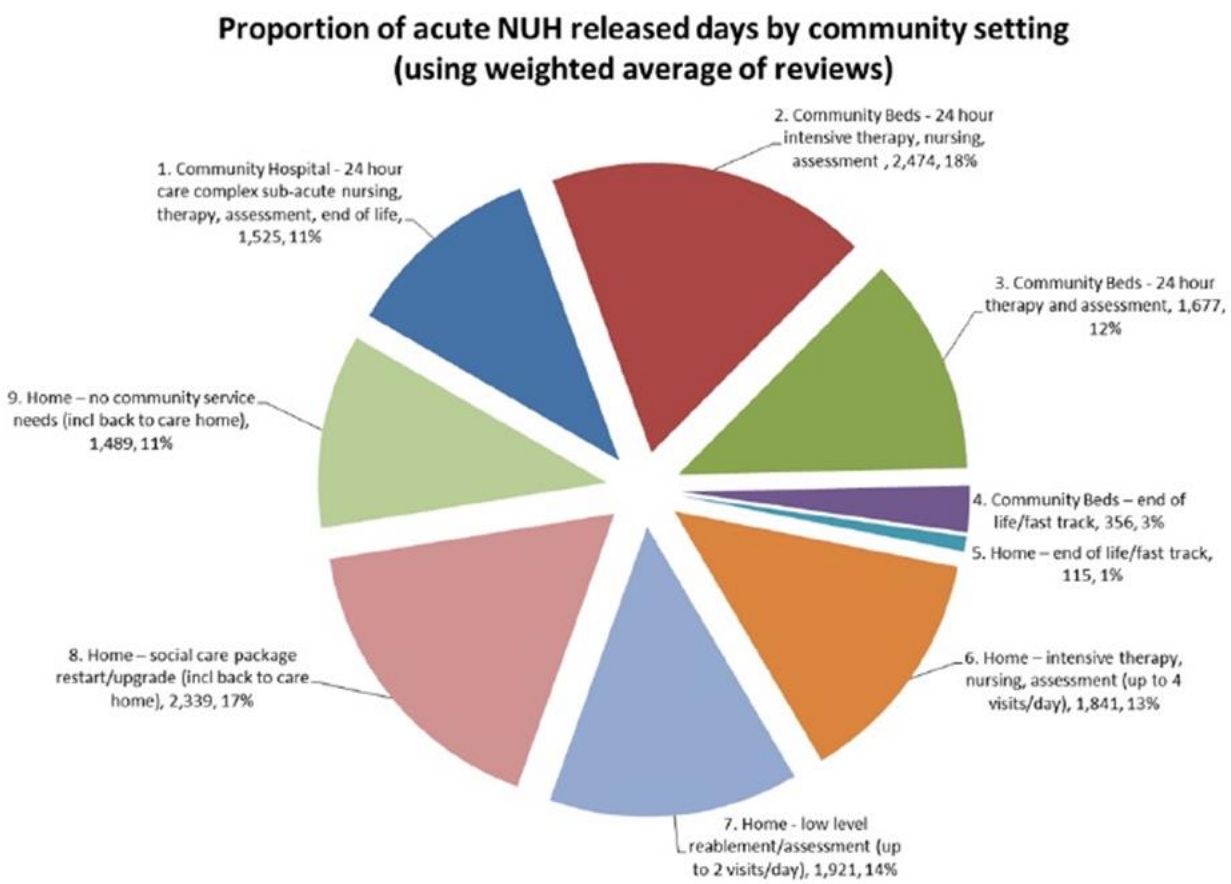
	bed days of the 3,794 bed days in the scope of the review.	
Almost all patients who were in appropriately admitted could be managed in their home environment. 71% of those who did not meet the admission criteria required Home Care and a variety of health and social care services.	Assessment for new and increased social care packages was cited as the most frequent factor delaying discharge (40.8% patients where the reasons for delay were external).	There were 1,464 inappropriate admissions and 1,012 inappropriate continuing stays, based on ALOC.
The majority of patients admitted to were usually referred by an acute hospital (38%). 10% from within the intermediate care services themselves and only 5% by a GP.	50% of the patients who could have been cared for outside the community hospital setting and whose discharges were delayed for internal reasons were either awaiting clinical assessment by occupational therapists or awaiting a home occupational therapy assessment.	2,477 patients per annum could be cared for at alternative locations according to the utilisation review methodology, with a potential 13,414 released acute days per annum.
Patients remain in the intermediate care series longer than necessary. Almost all patients who stopped meeting criteria could have been managed at home with a variety of health and social care services. 71% required Home Care, 16% could have managed at home with an outpatient follow up and 5% could have managed at home without any input.	Review highlighted the need for improvement in discharge planning and service co-ordination; need for increased capacity to manage patients at home; and reduction in the length of stay.	
These patients were remaining longer than necessary mainly due to internal issues.	Difficult or complex care needs should be referred to an integrated discharge team at an early stage with clear single documentation setting out timelines for decisions/criteria/care packages/discharge.	

Capacity Reviews

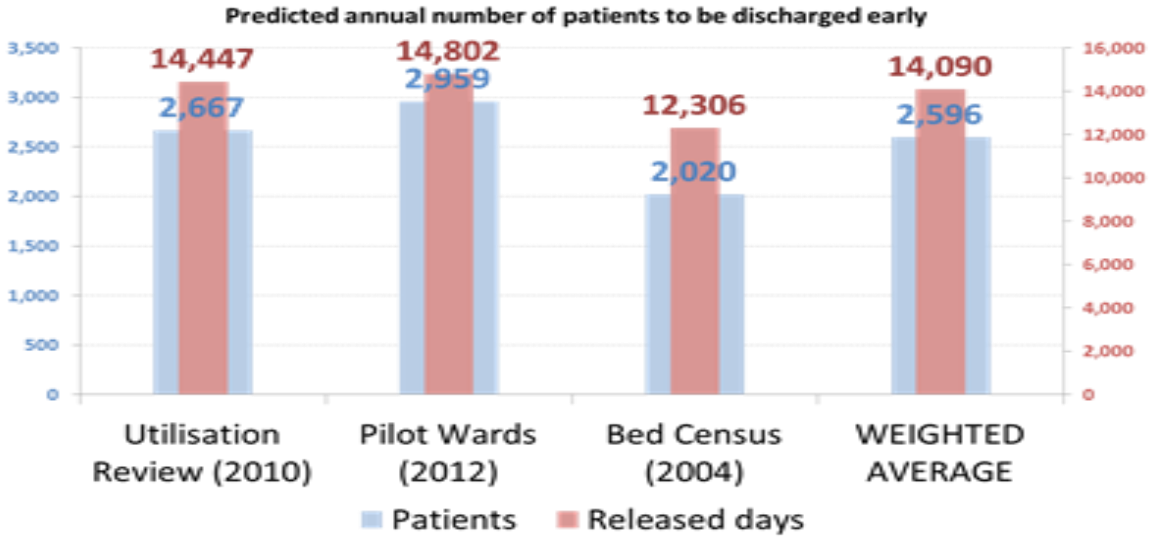
Building upon the utilisation reviews a further piece of modelling work was commissioned by the Transfer to Assess Outcomes and Commissioning Group in 2013. The purpose of this piece of work was to establish how much extra capacity is required across the primary and community care sector to enable the transfer of care.

This estimated that providing an additional 25 community beds and 25 community places would enable patients delayed in NUH to transfer out of NUH approximately 5 days sooner. If patients from other areas are excluded an additional 20 community beds and 22 community places would be needed in Nottingham City and South County CCG areas.

The chart below shows the apportionment of this additional capacity by community setting.



Commissioners and providers worked together to undertake detailed analysis and modelling using 2012 activity figures to show that there are 38 patients in beds in NUH who could be elsewhere. This equates to 7 additional discharges a day and an average reduction in delays of 5 days per patient.



Choose to Admit Transfer To Assess modelling

Since the production of the community capacity review in 2013 commissioners at Nottingham City CCG have done a further piece of work to review the activity and

demand for reablement and community beds across health and social care in Nottingham.

This work has been carried out to inform the development of services to support the Independence Pathway based on the "Choose to Admit – Transfer to Assess" methodology detailed below: -

"Choose to Admit" is the ambition that patients are only admitted to hospital if that is where they need to be rather than because alternative community based services are not available when they are needed.

"*Transfer to Assess*" aims to assess people for on-going long term care needs after a hospital stay in their own homes rather than in the hospital and to give them time to recover sufficiently before these longer term decisions are made.

The results of this modelling are described below by level of complexity and care setting.

Table.2 Summary of annual activity data for 13-14, including demand and gap in capacity for each service.

Level of complexity	Care setting	Baseline hospital (current access to services - no of people)	Baseline community (current access to services - no of people)	Total Activity (no of people)	Demand from modelling	Gap
High	Community beds	339	N/A	339	12 beds / 156 patients	12 beds / 156 patients
	Community Hospital	227	N/A	227		
Medium	Health reablement	423	459	882	138.84	138.84
Low	LA reablement			927	1752	825
	Urgent Care	620	830	1450		

The patient voice

In addition to the quantitative data which is described above we also have strong qualitative data i.e. *the patient voice* on their ambitions for the future which we will respond to through BCF Schemes. The Ada and Maureen animations were produced for staff and stakeholders to convey the need for integration from the patient's perspective. The animations outline the issues that the Integrated Care Programme aims to address.

At her most vulnerable, Ada receives the care and treatment she requires but she is passed between different services, seen by different teams and quickly loses her independence and confidence.

"Ada" can be accessed at the following link:
http://vimeo.com/57594278

We believe that Ada's story could be different and have created Ada part two which aims

to show how Ada's care can be provided when health and social care services are integrated through this pooled budget and Integrated Care Programme. http://vimeo.com/80986562

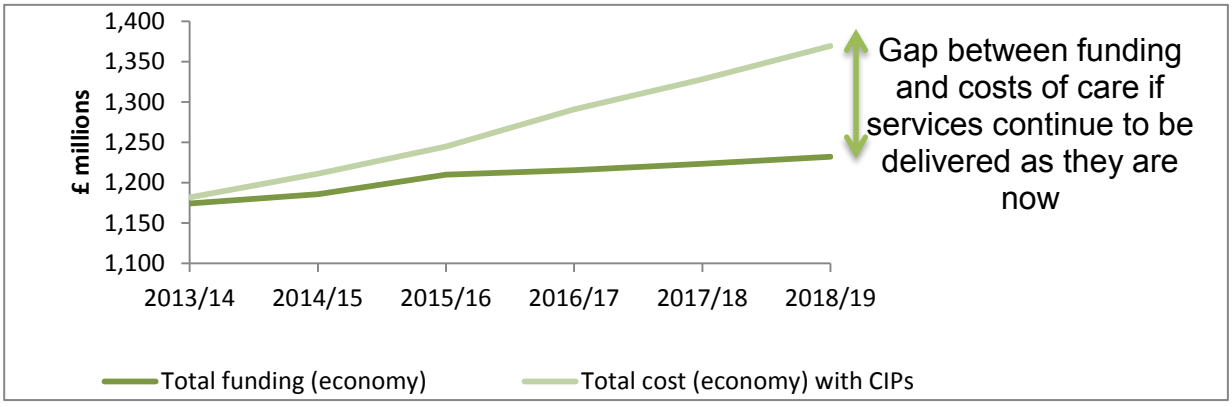
Resource gaps

Analysis has shown that if we continue with the current model of healthcare and expected funding levels there could be a national funding gap of £30bn between 2013/14 and 2020/21 which will only continue to grow if no action is taken. This is on top of the £20bn of efficiency savings which are already being met.

Local analysis completed as part of the South Nottinghamshire Unit of Planning shows that the total spend on health and social care by the four CCGs and two local authorities (Nottingham City and Nottinghamshire County Council) in South Nottinghamshire is in the region of £1,174m. This includes NHS England expenditure on primary care (GP, dental, ophthalmic and pharmaceutical services) even though these are not strictly within the control of the South Nottinghamshire Transformation Board. It does not, however, include NHS England expenditure on specialised services. Likewise other local authority services, such as public health services, are also excluded.

Spend on acute services at £403m (34%) represents the largest spend in the health and social care economy. Adult social care is the next highest at £264m (22%), followed by primary care at £245m (21%). Continuing care at £48m (4%) and community care and mental health care at £90m (8%) each are next, with ambulance services representing the lowest spend at £22m (2%).

If services continue to be delivered as they are now, it is estimated that in five years there will be a gap of around £140 million between the amount of funding available and the cost of delivering health social care in South Nottinghamshire as shown by Figure.3 below.



The NHS is not alone in facing financial pressures; this was highlighted by the results of the 2014 Association of Directors of Adult Social Services (ADASS) survey, which warned that the present system of social care is becoming 'unsustainable'. During the past four years, more than £3.5 billion in savings have had to be found, with further savings to be required (ADASS 2014).

Further to this, the final report by The King's Fund independent Commission on the

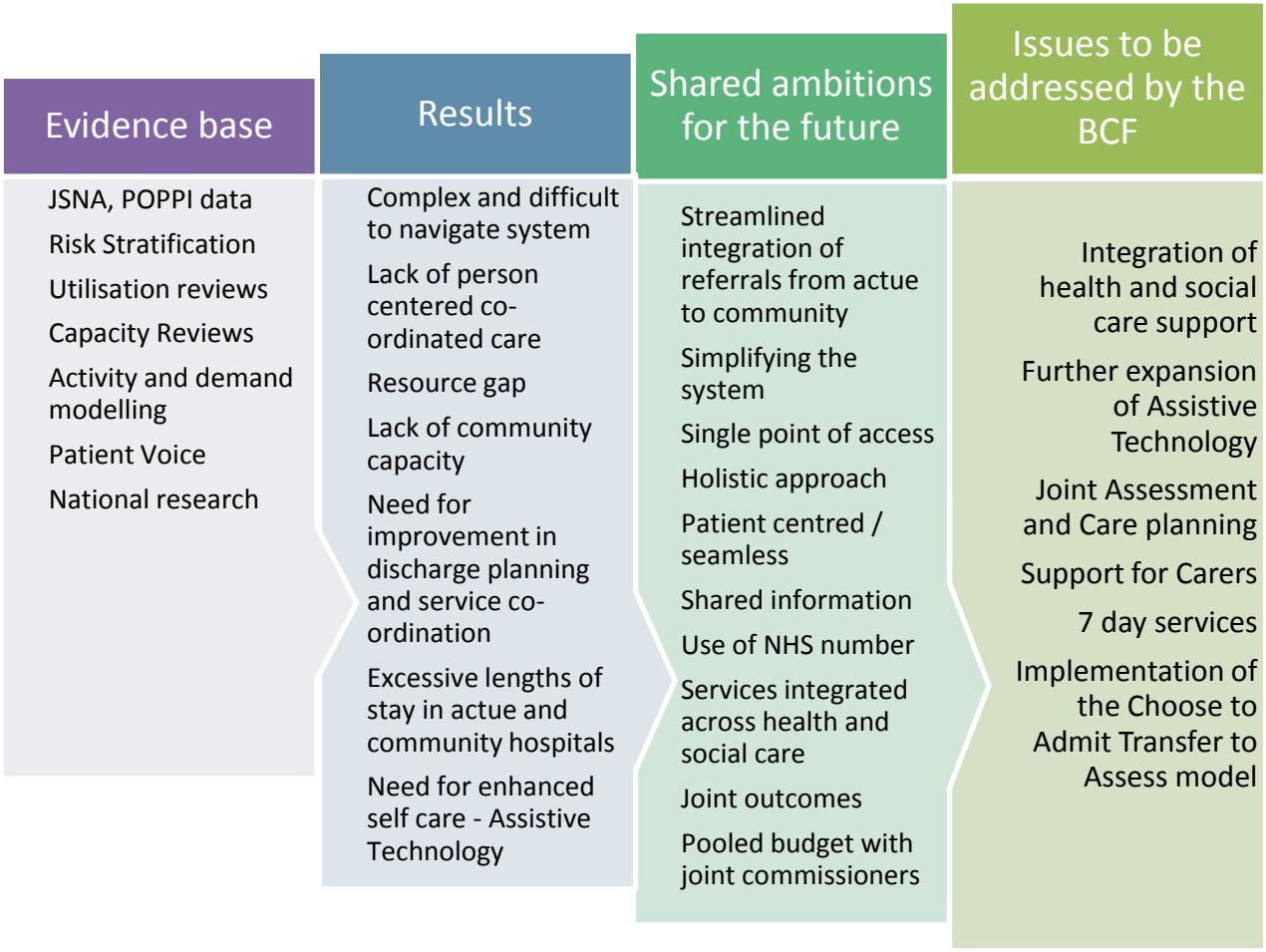
Future of Health and Social Care in England (September, 2014) strongly suggests that we need to move to a single, ring-fenced budget for health and social care with a single local commissioner. Whilst the report recommends this as a direction of travel, it does not make any recommendations as to whom the single local commissioners should or could be. Pooling of our local health and social care budgets through the Better Care Funds will provide an opportunity for Nottingham to drive streamlined transformation.

Conclusion of the evidence- *The case for change in Nottingham*

Pressures on both health and social care budgets coupled with demographic and social pressures necessitate the need to affect transformative change in the way in which we meet the needs of some of the most vulnerable members of our community.

We need to increase the capacity of community services, specifically reablement services to prevent hospital admission and facilitate timely discharge, releasing costs within the system. This will ultimately improve patient choice as patients will be able to make decisions about their future in a stable environment following a period of reablement; as a pose to the current situation whereby long term decisions are often made in a crisis situation.

The diagram below describes the link between the evidence analysed, the results, our ambitions for change in Nottingham and how we will meet unmet need through BCF.



4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Table.3 Better Care Fund High Level Plan

Milestone	**Achieved by**	**Key interdependencies**
Establish Care Delivery Groups incorporating GP practices and neighbourhood multi-disciplinary teams and care coordinators Development of CDGs to deliver proactive, joined up care. Including the integration of specialist services where appropriate.	January 2014 April 2015	 Primary care vision Connected Nottinghamshire (IT programme)
Align operational processes of reablement services to support integration Fully integrate reablement services	April 2014 April 2016	 Community service contract procurement April 2016
Expand assistive technology service through an integrated operating model	April 2015	
Implement choose to admit/ transfer to assess	October 2014	NUH organisational development
Integrate Nottingham health and care point (community health and social care single point of access)	April 2015	
Introduce 7 day working in conjunction with primary care and secondary care	April 2015	Primary care vision
Introduce a joint assessment and care planning approach	April 2015	Connected Nottinghamshire (IT programme)
Formalise links to community and voluntary sector	October 2015	Looking after each other programme

Establish a new commissioning approach 'accountable care system' to support integration	April 2016	Community service contract procurement April 2016
Further develop detailed financial modelling of scheme impacts to support benefits realisation and performance monitoring of schemes	April 2015	

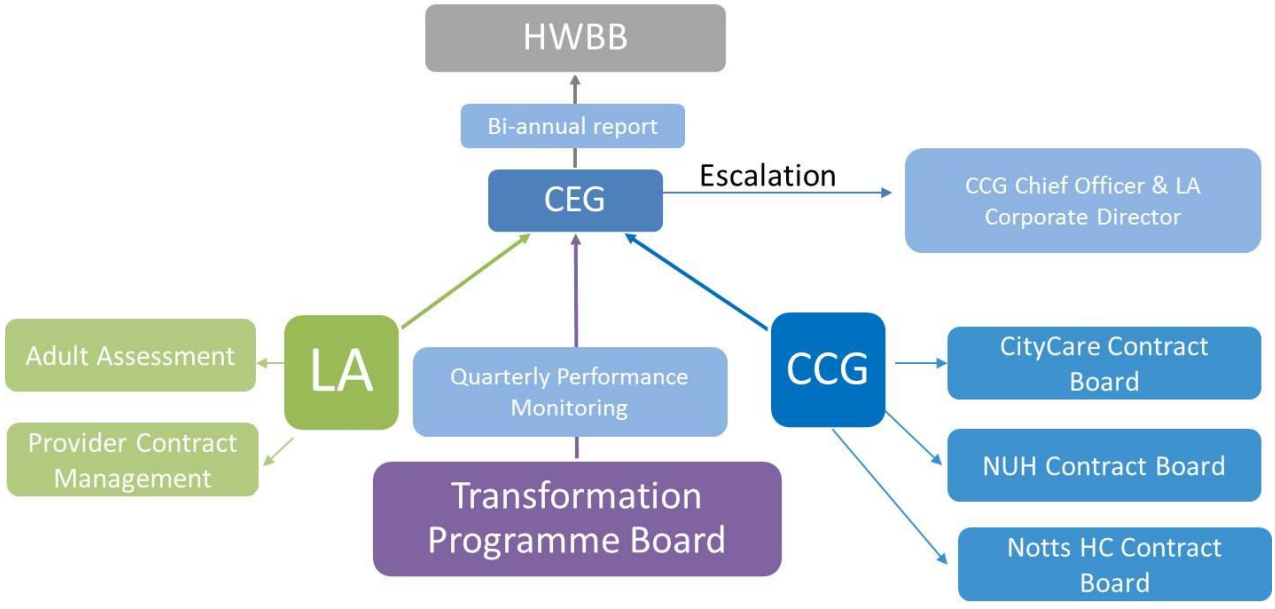
For more detailed project timelines see Attachment 09.

b) Please articulate the overarching governance arrangements for integrated care locally

The Commissioning Executive Group (a commissioning sub group of the Health and Wellbeing Board) will hold this transformation to account under the Integrated Care Programme in which clinicians, providers and the Local Authority are key members.

Through monthly meetings the HWBCEG will regularly evaluate programme delivery and financial benefits realisation, ensuring that there are high levels of satisfaction with services through patient, carer and staff feedback, via a performance dashboard of integrated care metrics. Strategic issues will be dealt with through HWBCEG. An Annual Report will be presented to the Health and Wellbeing Board and subsequent Governing bodies. (Please see governance chart below).

As an overarching principle, accountability for performance, mitigation of risks, and any remedial action will be managed wherever possible at the Commissioning Executive Group level and will be monitored and overseen through the aforementioned BCF governance process. A partnership agreement will be drawn up to formalise the BCF management arrangements.



c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

The management of the Better Care Fund will be the responsibility of the Assistant Director of Transformation, a new shared position between the CCG and Nottingham City Council.

The Assistant Director of Transformation will be responsible for establishing robust governance processes to ensure oversight of the plan reporting to the Health and Wellbeing Board. Performance reports will be reviewed at the Commissioning Executive Group on a regular basis to ensure that an action plan is in place should the plan go off track.

The Assistant Director of Transformation will have direct links with the commissioning leads for integration in the CCG and Nottingham City Council and escalate operational issues affecting delivery of the plan. This will build upon successful work with commissioners in health and social care to jointly commission services to support Integrated Care, such as the Care Delivery Group Link Social Workers. This demonstrates that strong leadership across the Health and Wellbeing Board is already in place to deliver transformation.

d) List of planned BCF schemes

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Programme Management
2	Access & Navigation
3	Assistive Technology
4	Carers
5	Coordinated Care
6	Disabled Facilities Grant
7	Independence Pathway

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
There is a risk that the sign up and cultural changes required to enable whole scale change from all partner organisations, including changes to ways of working is not achieved	3	4 User experience and outcomes remain unchanged/ worsen Staff satisfaction remains unchanged / worsens Organisation (health and social care, commissioner and provider) failure / System failure	12	1) On-going leadership from the Integrated Care programme Board and CEG *Lead: Director leads CCG and Nottingham City Council* *Timeline: ongoing* 2) Partner organisations 'sign up' to a Compact Agreement for system – wide transformational change. *Lead : Director of Transformation*

				Timeline: i) Compact developed September 2014; ii) Endorsed by governing bodies in October 2014; iii) Monitored through South Notts Transformation Board (SNTB) on an ongoing basis. 3) Programme of organisational development in place for SNTB at senior executive level led by an external critical friend and addressing issues such as agreeing a core purpose, shared mechanisms for managing financial risk and benefit. *Lead: Director of Transformation* *Timeline: monthly sessions commenced June 2014 and run until March 2015 when assessment of needs for 2015/16 will be undertaken.* 4) Develop, agree and implement a system wide OD plan across South Notts This will build on the workforce development which has taken place as part of the integrated Care programme over the last 2 years. *Lead Director of Transformation* *Timeline: i) Development of plan Oct-Nov 2014; ii) approval by SNTB Nov 2014; iii) Oversight of delivery by SNTB throughout 2015 and beyond.*
There is a risk that the	3	4	12	1) On-going leadership from the Integrated

current workforce profile and recruitment / retention difficulties could impact negatively on timely delivery of schemes.		User experience and outcomes remain unchanged/ worsen Staff satisfaction remains unchanged / worsens Workforce numbers decrease. Increased use of agency / temporary staff. Failure to deliver new models of care and realise the benefits of new ways of working.		care Programme Board and CEG *Lead: Director leads CCG and Nottingham City Council* *Timeline: ongoing* 2) Collaboration with community providers to ensure training and development programmes are in place to manage influx and increase of skills needed. Work with HR to ensure staff are engaged with during the process and undertake training needs analysis. *Lead: Director leads CCG and Nottingham City Council* *Timeline: ongoing* 3) On-going regular engagement and communication with workforce. Produce and circulate the 'Connecting Care' newsletter bimonthly. *Lead: Director leads CCG and Nottingham City Council* *Timeline: ongoing* 4) Strengthened links to health education east Midlands and the Nottinghamshire local

				education and Training Committee to secure advise and support and gain links to wider initiatives. *Lead: Director of Transformation* *Timeline: Ongoing*
There is a risk that if the existing contractual arrangements with providers remain unchanged this will have a negative impact on delivery of the plan	4	4 System failure to achieve benefits from the programme. Commissioner failure to realise financial benefits.	16	1) On-going leadership from the Integrated Care programme board and CEG *Lead: Director leads CCG and Nottingham City Council* *Timeline: ongoing* 2) Early engagement of partners with work programmes agreed in partnership at a senior level to enable readiness for contractual changes. *Lead: Director leads CCG and Nottingham City Council* *Timeline: ongoing* 3) Programme of organisational development in place for SNTB at senior executive level led by an external critical friend and addressing issues such as agreeing a core purpose, shared mechanisms for managing financial risk and benefit.

				Lead: Director of Transformation *Timeline: monthly sessions commenced June 2014 and run until March 2015 when assessment of needs for 2015/16 will be undertaken.*
There is a risk that as performance related funding is reliant on outcomes these may not be evidenced in the short to medium term	3	3 Commissioner failure to realise financial benefits	9	On-going monitoring of outcomes at a senior level through the Integrated Care Programme Board and Commissioning Executive Group with a robust approach to performance management. *Lead: Director leads CCG and Nottingham City Council* *Timeline: ongoing* On-going monitoring and evaluation of programme to ensure that services/projects within the programme are fit for purpose and meeting expected outcomes within timescales. *Lead: Director leads CCG and Nottingham City Council* *Timeline: ongoing* Services to be procured on an outcomes basis with funding linked to outcomes therefore a shared risk between commissioners and providers. *Lead: Director leads CCG and Nottingham City Council*

				Timeline: i) plan to be developed by October 2014; ii) Implementation planned from 2015 - 2019
Future changes to national policy in respect of Urgent and Emergency Care (primary care, A&E and OOH) and changes to the primary care contract may impact on delivery of the plan	3	3	9	Maintain and sustain strong links and communication channels with Area Team, NHS England. *Lead: Director leads CCG and Nottingham City Council* *Timeline: ongoing*
There is a risk that social care funding challenges result in a reduction of care packages to support long term care and resources to support assessment.	4	3 Potential for health commissioners to have to redirect resources to support the plan.	12	Ensure individual projects and overall programme are subject to robust analysis and modelling to ensure that the impact of funding cuts is identified and included. *Lead: Director leads CCG and Nottingham City Council* *Timeline: ongoing* Development of whole health and social care system financial plan for 2015/16 to 2018/19 *Lead: Director of Transformation* *Timeline: i) Initial plan December 2014; ii) plan further developed and refreshed on an ongoing basis.*
Increased demand for Carers	3	3	9	Continued demand modelling and strong focus on

provision as a result of the Care Act exceeds capacity to respond				outcomes in commissioned provision. Developing community capacity through links to other initiatives such as the Looking After Each Other programme. Engagement in National work to model the implications of the Care Act and funding requirements arising from it. *Lead: Director lead Nottingham City Council* *Timeline: ongoing*
There is a risk that there is public resistance to the proposed changes and that population behaviour change will not materialise.	2	3 Decreased user satisfaction Failure to deliver new models of care and realise the benefits of new ways of working.	6	Plan to be supported by the on-going development and implementation of a communication and engagement strategy. *Lead: Director leads CCG and Nottingham City Council* *Timeline: ongoing*
Work is underway to revise the reporting process on Delayed Transfers of Care (DTOC). It is acknowledged that there is a level of under-reporting and there is a risk that the implementation of the revised reporting process will impact upon our ability to meet our DTOC targets against the current baseline	4	3	12	Ensure that all reporting against this target includes a detailed description in the changes to local reporting processes and the consequences. *Lead: Director leads CCG and Nottingham City Council* *Timeline: ongoing*

Data sharing risks: section 7C:				
Organisational systems won't be able to support the use of the NHS number as the key identifier now or in the future	1	3	4	All identified systems across Nottinghamshire are now able to support the NHS number. Future systems would be specified with this as a requirement. Where an legacy system needs to provide information that may not have the ability the integration software would provide a mechanism to hold multiple indexes to allow matching externally to the system. *Lead: Connected Notts Programme Director* *Timeline: ongoing*
NHS number matching may not be possible in a timely manner impacting early identification of Primary Key Identifier	2	3	6	Plans are in place across all organisations to ensure NHS number is populated manually via process or automated. *Lead: Connected Notts Programme Director* *Timeline: ongoing*
Staff may not use the NHS number early enough or at all in communicating/identification	2	3	6	Organisational change management plans (including training and communication) will be closely monitored. *Lead: Connected Notts Programme Director* *Timeline: ongoing*
The integration technology required to support electronic communication of information (and later workflow) may not be delivered in the required	2	3	6	Interim solutions are being put in place that could be further expanded should this occur. Delays could be managed but efficiency/ease of access to information would be impacted.

timescales due to affordability. This would prevent elements of the business process changes				*Lead: Connected Notts Programme Director* *Timeline: ongoing*
Key systems may not have published API's (and supplier unable to provide) preventing the sharing of information in a timely way	2	2	4	Although this risk is difficult to militate against the ability to provide alternative mechanisms to data will ensure that this does not impact on progress. *Lead: Director leads CCG and Nottingham City Council* *Timeline: ongoing due to local procurement and system changes. Target date April 2015*
Required standards may not have been specified	4	2	8	This risk is very likely to occur but with the Nottinghamshire IT Managers working group and the Data Advisory Group it is felt that there is a suitable operation body to define local standards. In addition any required standards not in place would be identified to the appropriate body (Health or Social care) to lobby for the creation of an appropriate Information Standard Bulletin (ISB) via the Health and Social Care Information Centre. *Lead: Director leads CCG and Nottingham City Council* *Timeline: ongoing Data advisory group to define local standards. Target date April 2015*
Systems may not be able to manage the approved/chosen consent	3	3	9	Whilst it is recognised that not all systems will support an advance or even basic consent capture and management it is felt that there are alternate

model				methods to support this work should this be the cases limiting the impact. *Lead: Director leads CCG and Nottingham City Council* *Timeline: Completion of standard consent form and rollout January 2015*
Staff may be risk-adverse to sharing information via electronic systems	2	3	6	There will be some staff and some elements of data that it will be difficult to get staff to share routinely. This is why the communication and clinical leadership built into this work is vitally important and is considered good mitigation. *Lead: Director leads CCG and Nottingham City Council* *Timeline: Completion and sign up to updated information sharing protocol January 2015*
One or more organisation may not accept the strategic direction for IG preventing the data required for care to be shared	2	3	6	Connected Nottinghamshire has very senior level engagement and with the positive impact of the Records and Information Sharing Group the likelihood of this is considered low *Lead: Director leads CCG and Nottingham City Council* *Timeline: Confirm consent model to be implemented as part of Nottinghamshire Care Record integration tool work Target date April 2015*

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Nottingham City Council and Nottingham City CCG have agreed a 50/50 risk share agreement to cover any overall failure to meet the BCF target for a reduction in non-elective emergency admissions.

Financial value of Non Elective Saving/performance Fund (as per Nottingham City Plan – P4P tab, Part 2)	£1,556,052
CCG risk element (50%)	£778,026
City Council risk element (50%)	£778,026

In relation to the BCF targets, the CCG has already put in place a planned 3.5% reduction in emergency admissions for 2014/15 as well as planned reductions in relation to on-going QIPP schemes with its main acute provider. The CCG is working together with the provider to ensure that these reductions are maintained and that the contract for 2015/16 includes a risk sharing arrangement to cover the continuation of the 3.5% target.

Concerted efforts are being made across the local health and social care economy in a number of ways to ensure that these reductions are achieved. For instance, senior leaders meet on a weekly basis through the System Resilience Group to escalate and resolve issues. In addition an Urgent Care Programme Director has recently been appointed on behalf of the City and County CCGs to lead on this agenda. However, given the challenging nature of our non-elective admissions target within the timeframe we consider the full £1.5 million to be at risk.

CCGs have historically managed activity variances and have a number of process and governance structures in place to identify these early and mitigate. In relation to the BCF schemes performance against all metrics, including the P4P non-elective admissions metric will be reported on and managed through the Commissioning Executive Group (CEG) which reports to the Health and Wellbeing Board, this will be overseen by the Assistant Director of Transformation. The chair of the Health and Wellbeing Board is aware of our plan of action, and although the Board will not meet until early October members of the Board will have sight of the plan before submission.

CCGs hold both contingency and specific risk reserves based on calculated risk at plan stage, so these resources will be utilised should investment be needed for any mitigation or corrective action.

Mechanisms also exist and are built into provider contracts to manage and minimise the impact of any variation in the system. Furthermore, the whole focus of the schemes in the BCF plans are geared towards admissions avoidance and the implementation of these (and therefore the investment) will be done in a planned and managed way to allow

flexibility to transfer resource should there be any slippage within the schemes.

In addition, it is important to note that the schemes currently being implemented that focus on admissions avoidance have been developed across the health and social care community through the Integrated Care Programme. This has involved full engagement with community and local authority colleagues. Each scheme has its own set of risks which have been identified within the risk log alongside mitigating actions.
There are numerous precedents for risk sharing in Nottingham. For instance, a financial risk pooling agreement for 2014/15 has been agreed by the City CCG alongside Nottinghamshire CCGs that covers acute and critical care high costs patients, as well as 'one- off' major incidents. Furthermore, health and social care have an established history of managing risk through large elements of joint section 256 spending on reablement and other mutual priorities.

Another example would be the Integrated Community Equipment Service (ICES) formed in Nottinghamshire in April in 2004. This is a risk sharing partnership between local authorities and health organisations. In April 2011 it was commissioned as a countywide service, currently operated by the British Red Cross and managed by Nottinghamshire County Council.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

Nottingham Adult Integrated Care Programme

The Integrated Adult Care programme in the City described throughout the document is key to the delivery the Better Care Fund Plan. Governance of the programme through the HWB ensures alignment with other strategic priorities including Housing.
The Programme has its own identity (Connecting Care) with a commissioned provider to ensure effective communication of the development of the implementation of the programme including regular newsletters to the Health and Social care and VCS workforce relating to the development of the Integrated Care Programme. An external evaluation of the programme is also in place.

Health and Well-Being Strategy

The BCF Plan is aligned with the Health and Well-Being Strategy 2013-16 priorities to *"improve the experience of and access to health and social care services for citizens who are elderly or who have long-term conditions".* The plan will assist with the further transformation of social care and health service delivery instigated by the implementation of personal budgets. Through more effective care co-ordination person centred planning will inform **all** service delivery and the emphasis on preventative and community based service provision will be protected and enhanced. Multidisciplinary working through Care Delivery Groups and joint Commissioning of Health and Social Care Independence pathway service provision will further enhance social care transformation enabling the

development of trusted reviewer and assessor functions.

Nottingham Housing Strategy

The BCF Plan aligns with Nottingham Housing Strategy 2013-15 which contains objectives to continue to provide housing adaptations for disabled people and make best use of existing adapted stock and further expansion of assistive technology. Funding of adaptations and assistive technology through the BCF will ensure that interdependencies between Housing Strategy Integrated Care will be more effectively managed. The BCF will also underpin the Delivery of the joint Council and CCG Vulnerable Adults Plan which has 3 strands: A radical change in approach underpinned by much greater investment in prevention and early intervention, particularly where needs and costs are already increasing significantly; Focus on building community capacity, personalisation and increased citizen choice; Joint working to drive collaboration, integration and efficiencies between providers, citizens and partners.

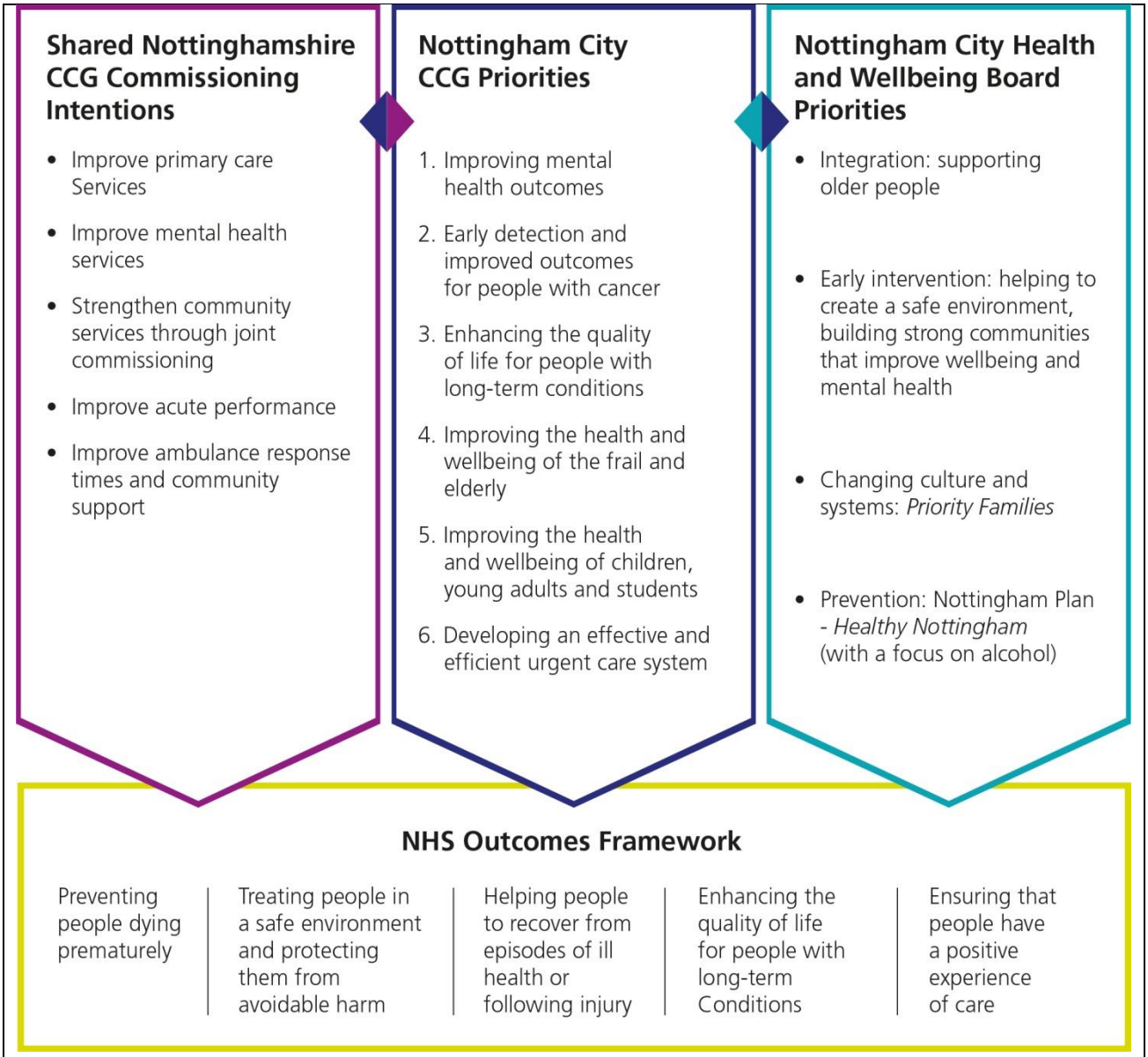
Looking After Each Other (LAEO) Programme

The LAEO programme is a joint Council and CCG initiative launched in 2014 to encourage and support community based initiatives and enhance community capacity to develop and deliver mutual support networks. LAEO will support the delivery of BCF objectives to enable vulnerable adults to live independently in their own homes for longer by addressing social isolation. LAEO reports to the Commissioning Executive Group of the Health and Well-being Board.

Wider health and care system alignment

Figure four below shows how the CCGs priorities align with the shared partnership priorities of the Health and Wellbeing Board (including Nottingham City Council), NHS CCG Commissioning partners across Nottinghamshire and the five priority areas set out within the NHS Outcomes framework.

Figure 4. Alignment of CCG priorities with those of our partners



Furthermore, there is a system resilience plan that aligns fully to the BCF plan, and will contribute significantly to the delivery of the BCF outcomes, particularly around urgent care. There are interdependencies between system resilience and BCF planning through the sharing of plans and KPIs, and collaboration of partners working across the system and the shared focus of integration of services across health and social care.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

In September 2013, Nottingham City CCG and the three South Nottinghamshire CCGs came together in a unit of planning engaging citizens and partner organisations (NHS England, local government, and provider organisations) in the development of a unifying vision together with a two-year operating plan and five-year strategy, ensuring alignment with other local plans – including the BCF.

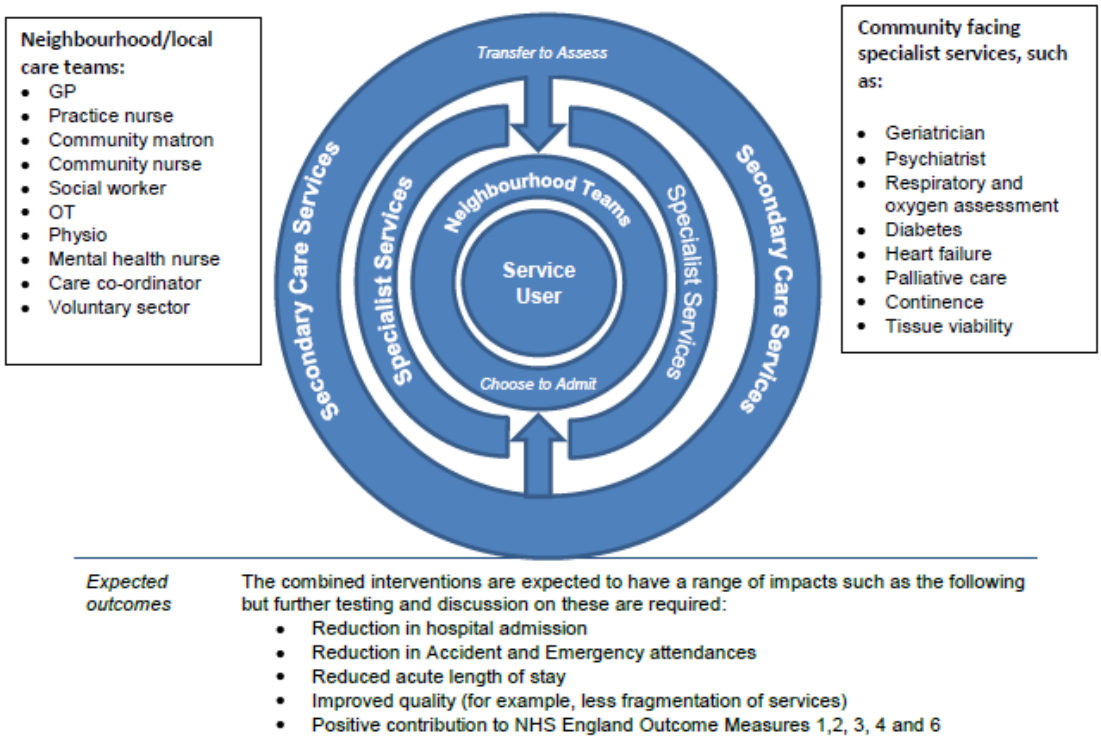
Our BCF plan supports the objectives of the 5 year strategic plan described below and all

schemes within the BCF are included in the 2 year plan.

System Objective One: Increase the proportion of people living independently at home
System Objective Two: Reduce time spent unavoidably in hospital through more and better integrated care
System Objective Three: Improve the health related quality of life of those with long-term conditions including mental health conditions
System Objective Four: Secure additional years of life for people with treatable mental and physical health conditions (Parity of Esteem)
System Objective Five: Engage with the local population to support behaviour change, promote public health messages and to ensure efficient use of healthcare resources
System Objective Six: Support quality of services – safe and avoidable harm and clinical effectiveness
System Objective Seven: Deliver services which optimise patient/citizen experience; reflect best practice and deliver the NHS Constitution

Our Integrated care model, described in section 2, developed jointly with our citizens provides a local interpretation of the South Notts Integrated care model (Figure.5).

Figure 5. Outline of the reconfigured integrated care model supporting proactive care



c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.
-

Following receipt of the letter from Rosamond Roughton and Dame Barbara Hakin concerning co-commissioning of Primary Care discussions took place regarding the options and the advantages and disadvantages. As a member organisation we obtained detailed feedback and opinion by encouraging and describing in detail the option appraisals at our member 'cluster' boards, in which representatives from all practices were in attendance. This was supported by discussions at our Clinical and Peoples Councils, and the Clinical Commissioning Group's Governing Body.

The issues raised by stakeholders are as follows:

The advantages were:

- Making primary care commissioning more responsive and locally sensitive
- Allowing CCGs to develop flex around local contracts (PMS and APMS)
- Enabling primary care commissioning to be delivered in a more coherent fashion around the Health and Social Care Integration agenda / Better Care Fund work.

The disadvantages were:

- Currently there are no resources identified to support CCGs to take on extra work – this would be an issue given the current running cost allowance is already at its limit
- A risk of having being left with an increasing performance management role of member practices and individual GPs, this will make the conflict of interest challenges more intense

From the discussions held within the cluster boards, there seemed to be an initial consensus that having greater influence in the commissioning of primary care was appealing. However this appeal is based on the CCGs having more formal arrangements for engaging with the Area Team in the exercise of its commissioning functions for Primary Care. The CCG would particularly wish to influence decisions that may have an impact on its 5 year strategy and 2 year operating plan, and those which might impact on the sustainability of Primary Care. The CCG would also welcome collaborative opportunities of working with other CCGs and the Health and Wellbeing Boards.

The CCG has worked with primary care to ensure that practices have the tools to deliver the enhanced service and has been supporting NHS England. The CCG has funded primary care to deliver additional services above the scope of the enhanced service which will further embed the Health and Social Care Integration agenda / Better Care Fund work within primary care. In particular through proactive patient reviews with multi-disciplinary team member's services will enhance integration and cross practice/service working within care delivery groups, providing better outcomes for the patient. A key area is to proactively ask patients to consent to their clinical information being shared with multi-disciplinary team members and having monthly meetings with MDTs in practice to discuss patients at risk of admission/readmission.

A risk to the effective delivering of services which could impact on Better Care Fund work is engagement from practices, which could also provide an inequity in care provided to

patients across Nottingham City. However, the response from practices has been positive and this risk is low. Another risk could be the capacity of the MDT members to engage with practices for the monthly meetings, again, this risk is low as this has been built into the services and, through the care co-ordinators, only those MDT members that need to be present will be.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

The core commissioning Stakeholders can confirm that the eligibility criteria for accessing adult social care will remain the same. In Nottingham City the eligibility threshold is High Moderate.

In addition to maintaining the current eligibility criteria the local definition of protection for social care services includes the following:

- Ensuring that we can respond to demographic pressures/increasing levels of need in particular; dementia, long-term conditions and younger adults with complex care needs
- Promoting innovation in social care and integration with Health in line with transformation plans to improve social care outcomes and realise savings and efficiencies in both health and social care budgets
- Future proofing – capacity for Care Bill implementation
- Maintaining (not compromising) existing social care model – essential core services, enhancing personalisation, focus on support for carers, promoting enablement and reablement, building community capacity to deliver preventative services.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Protection of social care provision is integral to the delivery of an effective integrated care model in Nottingham and this is reflected in the inclusion of social care provision within each of the BCF plan schemes.

The focus on protection for social care services in Nottingham City is mitigating demand pressures and maintaining eligibility at the national standard as a minimum. This will not only ensure continued access to quality social care provision including homecare, day-care and day opportunities but enable maintenance of a preventative focus through further expansion of early intervention approaches including assistive technology and promotion of self care. The Independence Pathway strand of the Integrated Adult Care programme and BCF Plan enshrines a preventative approach through the development of a self-care pathway accessed through a joint Health and Care point and removal of FACS eligibility considerations for enablement and reablement provision. The aim of this approach is to encourage and support citizens to manage their condition within a

community setting as effectively as possible maximising the community resources available, thus reducing demand on more intensive health and care provision. This will run concurrently with Health Improvement initiatives to reduce health inequality and raise living standards that the City has committed to within the Nottingham Plan to 2020 and the Vulnerable Adults Plan. Such an approach is essential given identified demographic pressures contributing to increased demand for social care provision by 2020 including projected increases of: 15% in the over 85 population, 20% with diabetes, 10% with hypertension, coronary heart disease and COPD, 8% strokes. This equates to 13,000 new patients with a Long Term Condition

Additional specific social care services that will be protected through Better Care funding include:

- Community Alarm provision.
- Enablement Gateway function providing access to community provision and OT for those who are pre eligibility.
- Additional Hospital Discharge assessment posts
- Additional Specific Reablement Assessment Posts
- Additional Specific in-reach discharge posts
- Mental Health Reablement Service

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The total amount of funding within the BCF that has been allocated for protection of social care services is £6,806,970. The indicative local amount indicated for implementation of Care Act Duties from the national £135m pot is £841,000. This is reflected in the BCF plan with £468,000 apportioned for duties pertaining to eligibility threshold and support for carers with a further £373,000 apportioned for meeting other duties, predominantly costs associated with carer assessment. See attachment 06 for further details.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The delivery of an integrated health and social care system supported through the Better Care Fund will enable the social care and health community to be better placed to deliver requirements of the Care Act through the provision of a more efficient and better coordinated system of provision. A major imperative of the Integrated Adult Care Programme is to simplify access to and navigation through the Health and Social Care system ensuring that citizens and carers are able to access the right support at the right time including community based preventative provision. A programme board has been established to oversee implementation of the Care Act requirements. The Board feeds into the Commissioning Executive Group of the Health and Well-Being Board and is chaired by the chair of the Integrated Adult Care Programme Board. The Nottingham

BCF Plan contains specific proposals in relation to delivering minimum eligibility standards and better supporting carers. It should be noted, however, that the Nottingham BCF Plan does not contain provision for the additional demand on social care budget suggested by the Care Act the extent of which is still being scoped. Nottingham is fully engaged in on-going national work to scope additional demand and the additional finance required to resource this.

v) Please specify the level of resource that will be dedicated to carer-specific support

Just over £1m of the Nottingham Better Care Fund has been allocated to carer specific support. This includes: a universal Carers Hub provided by the Carers Federation to provide support and advice to all carers; specific provision for young carers; a 'pre eligibility' Carers respite service; specific end of life and dementia carers respite provision. Our carers model of provision has been co-produced with carers, reflective of priorities within our 2012-17 Nottingham City Joint Carers Strategy, and is designed to provide a holistic integrated response to different levels of carer need in order to offset identified demographic pressures associated with an increase of those with long-term conditions and the aging population of the City. There is an identified risk that demand for Carers provision may outstrip current and planned capacity as a result of increased awareness arising from the Care Act. The Care Act Programme Board will continue modelling demand for provision in partnership with Nottingham Carers organisations.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There is no material difference between this submission and the original other than inclusion of how Carers Act duties will be met within the plan.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

Nottingham City is committed to providing 7 day services and sees 7 day working as a critical component to support strategic principles. 7 day services will support hospital discharge and avoid admissions to both hospital and care homes.

Nottingham City currently has a number of 7 day services in place. A care coordination team has recently been commissioned to support discharges over 7 days. Reablement services, community nursing, the respiratory service, the diabetes service and some end of life services also cover 7 days to support people in their home wherever possible. The continuation and/or expansion of existing services are crucial to delivering the change required.

A working group is being established and will;-

- Comprehensively baseline the availability of key health and social care services in the community and identify gaps in provision, by end October 2014.
- Link planning to work underway in primary and secondary care.
- Develop an implementation plan to ensure that services are in place from April 2015 to support primary care and transfers of care from NUH.

The workforce will be involved in this planning through the on-going engagement activity which is an integral to the programme. Recruitment and retention of staff is a risk for the move to 7 day services (see risk log for mitigating actions).

Within Primary Care a one year pilot is being phased in from September 2014.

Aim of the pilot

The aim of the service is to pilot weekend opening to reduce the major pressures urgent care services are under, especially during the winter. This will enable patients to access treatment in primary care instead of attending A&E.

The service will pilot Saturday opening across all CDGs and test demand for Sunday opening in one CDG.

Objectives

The objectives of the service are:

- Improve access to health services in primary care
- Reduce pressures on urgent care services

Provide services in line with the 16 Care Quality Commission standards

Description

This service will provide extended access to face to face and telephone routine appointments with a GP and practice nurse outside of core times (and extended hours) to provide access to treatment at weekends. NHS Nottingham City CCG will continue to be responsible for the provision of urgent care outside of core hours.

As part of NHS Nottingham City CCG integrated care programme 8 Care Delivery Groups (CDGs) have been established. The provision of routine weekend appointments for patients will need to be provided to all patients in each CDG. The service will pilot Saturday opening across all CDGs and test demand for Sunday opening in one CDG.

As this is a limited resource, appointments will be available to those patients unable to attend the practice during a weekday. Appointments will be provided on a sessional (4 hours) basis (i.e. morning or afternoon each day based on demand after a period of awareness raising) at one practice (or more if required) in each CDG. It is expected that 18 GP appointments and 18 nurse appointments will be available (recognising nurses may require more double appointments). One hour administration time each for the nurse and GP is in addition to the appointments available.

A process for agreeing Action Plans with providers to deliver the clinical standards for 7 day services is in place. Contract negotiations have already taken place with providers, with final Action Plans to be agreed and varied into contracts. Key milestones and delivery timescales will be included within each provider contract as appropriate to that provider.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

An implementation plan has been developed for the use of the NHS number as the primary identifier for correspondence across Nottinghamshire Care Providers. Formal agreement has been reached across Health and Social Care providers that the NHS number will be the primary identifier across Health and Social Care records. Good progress has been made during 2014/15 for expansion of the NHS number use.

Introduction

The NHS Number is a unique 10 digit number assigned to every individual registered with the NHS in England and Wales. It is classed as Personal Identifiable Data (PID) as defined by the Data Protection Act 1998.

Use of the NHS Number has been mandatory within the NHS since September 2009(1). It is the common unique identifier that makes it possible to share patient information across the whole of the NHS safely, efficiently and accurately. The NHS number is the key to unlocking services such as the NHS Care Records Service, Choose and Book or

the Electronic Prescription Service.

Nottingham City Council is committed to the appropriate use of the NHS number within its CareFirst social care management information system. A project is underway to achieve this.

Summary of present project status:

The NHS Number is currently in use in all NHS organisations and used as the primary unique and unambiguous identifier, supporting communication with other providers of healthcare services for the purpose of direct patient care. With modern systems in place, the timeliness of NHS number matching is primarily at the point of contact via PDS linked PMI trace. Recent research Nottinghamshire wide puts tracing/use of NHS number at 98% in the main providers with the Ambulance Service matching 65% of electronic records within 24 hours.

Matching and recording of NHS number across social care systems is in place and on-going via direct entry or batch tracing of NHS number via PDS. Key systems have been modified to support the storage and use of the key identifier. Using the MACS Service, Social Care system data has been submitted from Nottingham City Council and matched to NHS numbers which is then data quality checked and uploaded. This work is progressing but there is still further work to be done, in particular on matching those records that do not return with a positive identification.

Early identification of the NHS number is important as it forms the underpinning link between records across all systems. For this reason processes have and must continue to be reviewed to ensure this happens at the first point of contact within the care system.

The idea of a Nottinghamshire wide integration system to provide the cross organisational data required to provide a “whole system” Nottinghamshire Care Record has been signed up to by all members of Connected Nottinghamshire. The Connected Nottinghamshire Programme of work is driving the strategic direction for this integrated record. It is hoped that a recent joint Nottinghamshire Health and Social care bid for national funding will provide a boost to the speed at which the technology to support this can be delivered.

A contractual Commissioning for Quality and Innovation (CQUIN) scheme has also been put in place with all NHS providers locally to drive information sharing and support this development. Until this new technology is available, cross-organisational access to systems at specific points of care delivery is being put in place to support the immediate operational needs for teams working across Health and Social Care. This “turn chair” type system access, whilst not ideal due to potential requirement for dual entry, gives the ability for care to be better coordinated. It offers visibility of all aspects of the care being delivered – this is one of the capabilities set out as a priority in the early business redesign workshops.

Project milestones

Action	Status	Estimated completion date
Establish clear governance parameters for project with Confidentiality Advisory Group (CAG) guidance	Underway	**April 2014**
Engage with Connecting Notts. to establish best practice basis for the project	Underway (see below)	**April 2014**
Review current use of NHS number by staff within adult social care	On track	**April 2014**
Conduct Privacy Impact Assessment	On track	**May 2014**
Review structure of CareFirst and determine changes required to accommodate NHS number	On track	**May 2014**
Completion of NHS number tracing by city council	On track	**September 2014**
Specify and test data extract re: batch data import into CareFirst	On track	**September 2014**
Import batch data into CareFirst	On track	**September 2014**
Develop and run data quality checking report	On track	**September 2014**
Provide guidance on the use of NHS number within adult social care	On track	**October 2014**
Project closure		**October 2014**
Post implementation review		**November 2014**

Stakeholders

Officer	Role	Organisation
Andy Evans	Programme Director	**Connected Notts.**
Linda Sellars	Chief Social Worker	**Nottingham City Council**
Elise Darragh	Insight Manager (Analytical)	**Nottingham City Council**
Anthony Childs	Information Manager	**Nottingham City Council**
Steve Harrison	N3 Lead Officer	**Nottingham City Council**
Steve Brookes	IT Application Manager	**Nottingham City Council**
OLM Systems	**Software developer**	**OLM Systems**

NHS Nottingham City and Nottingham City Local Health Authority are signed up to the Productive Notts IT Programme. A recent IT summit has been held in which all key provider organisations within Nottinghamshire have signed up to IT principles. These principles include shared information and data and the use of the NHS Number as the primary identifier. A rollout of shared data (including single use of the NHS Number) is now planned for summer 2014.

The table below sets out the next key milestones and expected/required dates. The overall plan is reported by the Connected Nottinghamshire Programme Director and monitored by the Connected Nottinghamshire Board. A number of the milestones are inter-organisational and some require cross organisational delivery.

Milestone	Date
Completion of NHS number tracing in Local Authorities(MACS)	September 2014
Processes in place for resolution of non-matched and on-going number matching	December 2014
Review of processes to ensure early identification of NHS number	(Continual review process as services come on line with NHS number access) Target date April 2015
Interim solution - Cross Organisational access to key systems (Framework, Carefirst, EMIS, SystmOne plus localised requirements for teams)	October 2014
Integration technology in place to support Nottinghamshire Care Record information sharing	January 2015 (phase one)
Integration technology in place to support Nottinghamshire Care Record workflow	October 2015

Risks

Connected Nottinghamshire manages the risks and issues associated with this work. The key risks relating to provision and use of the NHS number are included within the main risk log in section5a.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The Connected Nottinghamshire Programme has been setup to support integration across Heath and Social Care Providers in Nottinghamshire. With membership from Health and Social Care providers it maintains a strategic oversight of system developments. Part of this work is supporting the move to information that can follow the citizen/patient in a safe, secure and reliable way. This requires a number of functional requirements including the use of published open APIs. As part of any procurement exercise undertaken, the requirement for use and publication of Open APIs is now mandated.

Progress to date

A standards based approach is the strategic direction across Nottinghamshire and the Nottinghamshire IT Managers Group and Data Advisory Group, operating to support the Connected Nottinghamshire work at an operation level, supports this work setting the standards to use or working to create them where they do not exist. Whilst it is frustrating that there are not more Interoperability Tool Kit (ITK) standards to support enriched integration of information and messaging/workflow exchange, those that are available are used. Where they exist; standards based protocols, messaging and data standards are followed. These are either sector specific or IT best practice standards.

The issue of legacy system publication of APIs remains a challenge in some areas. Older legacy systems are an area where obtaining APIs are difficult. Some of these systems are based on non-current database and application/programing technologies. Assessment of the systems across Nottinghamshire has been carried out and although open APIs might not be available for all systems it is felt that there are credible, safe and secure mechanisms through which data can be accessed despite this when a form of integration platform is used (be that a localised integration engine or system wide integration tool). Hosted Primary Care and Community Care systems have been difficult to integrate in some areas but it is hoped that with the latest GP System of Choice (GPSoC) specification that this will change to allow easier cross system access.
The Commissioning for Quality and Innovation (CQUIN) scheme across NHS providers for information sharing supports providers developing mechanisms to provide cross organisational data flows. Whilst this work has started with the Comprehensive Geriatric Assessment and End of Life datasets it is anticipated that the integration technology put in place to support these will provide a platform for further developments.

Next Steps

Currently approximately 65% of existing systems have defined API's. It is anticipated that with the organisational migration plans currently in place that this will move to 95% in the next 18 months.

Part of the work to support the Nottinghamshire Care Record is assessment of provider's internal systems to identify API's. Where these are not available the alternate methods

for data exchange are to be identified. It is recognised that some data items may not be available in a real time but rather a batched or cached version of the data would be held. Assessment of the time sensitivity of these data items is part of the work to achieve the Nottinghamshire Care Record.

Milestone	Date
Assessment of key organisational systems and API statue	(On-going due to local organisational procurement/system changes and updates) Target date April 2015
Assessment of key data items to be shared and mechanisms to support sharing	April 2015
Data sharing via APIs or identification of alternate method	January 2015 (phase one)
Interim solution - Cross Organisational access to key systems (Framework, Carefirst, EMIS, SystmOne plus localised requirements for teams)	January 2015 (phase one)
Integration technology in place to support Nottinghamshire Care Record workflow	October 2015

Risks

Connected Nottinghamshire manages the risks and issues associated with this work. The key risks relating to provision and use of Open API's are shown in section 5a, risk log.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldecott 2.

Nottingham City is a member of the newly formed Record Sharing Group. This group comprising of clinical, and governance/ Caldecott leads works together as a health and social care community to develop and implement system-wide best-practice information policies that support the sharing of citizen information. This group works within best practice guidance to ensure the appropriate level of information is available to support the delivery of this programme, safely, securely and in line with legal requirements.
An information sharing agreement is currently in place to support the implementation of the Integrated Care programme. A standardised consent form is being developed (See attachment 07 for further details) to be shared across all providers to support the complex requirements of sharing across multiple providers. A communications campaign to highlight the need to share information is to be delivered alongside the launch of these new tools.

Progress to date

There is a mixture in the maturity of the information systems across Nottinghamshire. Some are very advanced and have complex models for IG consent. Other systems have little or no ability to collect information on consent to share. Part of the requirement for delivery of the Nottinghamshire Care Record and the integration technology that will support it, is that the ability to communicate, record and revoke consent is possible. This new technology will offer a way to manage consent across care providers.

The interim phase of information sharing is well underway and in relation to IG this is primarily internal system focused. Use of “turn chair” cross organisational access to systems in key parts of care provision is providing a mechanism to access information where systems aren’t joined up. Supporting this is the use of contractual arrangements for employment and confidentiality, information sharing agreements and the overarching information sharing protocol for Nottinghamshire (See attachment 08 for further details). All member organisations of the Records and Information Sharing Group complete the required Information Governance Toolkit returns and are meeting the required minimum standards. Working to implement the aims of the Caldecott 2 review is a core function of the group and in-particular to promote the sharing of information for direct care.

Work on the capture and use of consent against the NICE Clinical Quality Guidance is underway and forms part of the baseline work. Once this is completed it will give further intelligence on the future steps needed to support the best practice adoption of the best consent model.

Milestone	Date
Completion of standard consent form and roll out	January 2015
Completion and sign up to updated Information Sharing Protocol	January 2015
Confirm consent model to be implemented as part of Nottinghamshire Care Record integration tool work	April 2015
Baseline of consent	April 2015

Risks

The Records and Information Sharing Group reports into the Connected Nottinghamshire Programme Board and manages the risks and issues associated with this work. The key risks relating to the IG plan are shown in section 5a, risk log.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

As detailed in section 3 – *the case for change* risk stratification is in use across Nottingham City to identify those patients most at risk of a hospital admission.

A systematic process is employed to risk stratify the adult population of any GP practice population by using a Combined Predictive Model tool (Devon tool) this gives high accuracy levels predicting risk of hospital admission. The full approach is detailed in section 7dii below.

Reviewing the level of risk of the adult population in Nottingham reveals that 1.88% of the population are at high or very high risk of admission to hospital, as detailed in Table.4 below. The tool also demonstrate those patients whose risk score has rapidly increased within a given time frame and therefore may soon below a higher risk patient.

Risk Band	Risk Score	No. of Patients as of 1.9.2014	% Population
Very High	90-100	97	0.55%
High	80-90	230	1.30%
Moderate	60-80	983	5.57%
Low	50-60	1002	5.67%
Very Low Risk	0-50	15348	86.94%
Total		17,660	100%

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

The process which is currently used across health and social care teams to assess risk and plan care is described below:-

Risk stratification is done through the use of the Devon Risk Stratification tool (Combined Predictive Model (CPM)). This tool is hosted in eHealthscope, which is a locally developed data integration and processing tool. eHealthScope uses Hospital Episodes Statistics (HES) to calculate risk scores for each patient, reflecting their future risk of admission into hospital. Running data through this tool allows us to stratify patients according to their risk score and produce an overview of the number of patients in each stratum. This allows for specific patient cohorts to be prioritised for proactive preventative care, with the ultimate aim of improving patient quality and outcomes and the efficient use of resources.

An example of the risk of admission log is below: it details any admissions into hospital, including the spend. The current risk score is shown as well previous scores and notes any changes that have occurred. It shows at a glance if the patient is being reviewed by a particular team and also comments that were made that will enable better care. The risk

log also identifies the status of care planning for that patient, as either: Care Plan agreed; Care Plan in discussion; Care Plan unnecessary; No Care Plan in place; Care Plan drafted.

Risk More than 50 Risk Less than 100

Activity	Status	Risk	Change	Caseloads	Comment	Care Plan sorted?	Last updated
9 11	Action taken	**83.25** 79.99 92.93	↑		Under gastroenterology and under personality disorders clinic.Referred to Drug & alcohol team; DNAs appts and not always compliant with meds; alc related seizures; Try to get to see one GP **Care Plan agreed**	✓	20/02/2014 14:13:45
3 2	Not reviewed	**80.56** 73.31 80.56	↑		**No Care Plan in place**	✗	16/07/2014 12:47:11
5 5	Action taken	**78.81** 78.81 85.25		Community COPD	Under GP care with COPD nurses. On 4-6w co-amox course then CT scan **Care Plan agreed**	✓	20/02/2014 13:57:56
1 2	Not reviewed	**72.64** -- 72.64			**No Care Plan in place**	✗	
3 4	Action taken	**69.37** 41.6 69.37	↑ ↑	CICCS	Care package arranged in Sep - Not for CM-HON to consider falls referral **Care Plan agreed**	✓	24/03/2014 11:54:26
3 3	Not reviewed	**68.22** 44.09 68.22	↑ ↑		**No Care Plan in place**	✗	
2 2	Action taken	**66.09** 66.09 71.83			Seen by Adam Gordon's team. Refused hand surgery.Check respiratory function/asbestos exposure in past. **Care Plan agreed**	✓	29/05/2014 14:49:30

Our process allows health and social care staff in a multi-disciplinary team meeting to meet on a monthly basis, review their most at risk patients and target interventions according to need with intensive case management targeted at those most at risk.

Accountability is assured within the MDT process and the model pits the patient at the centre of care decisions and requires GP practices to play an active part in the MDT.

This process is supported by the Care Co-Ordinator for that Care Delivery Group. The Care Co-Ordinator will support the process and ensure that the team has all of the relevant information prior to the meeting; they will also record the outcomes of the meeting on both health and social care systems. Joint decisions re: management of patients will be made at multi-disciplinary meetings. Plans to identify a key worker (lead professional) supported by a joint assessment and care management process are currently underway.

Care plans are then developed around one of the following three approaches to Chronic diseases management.

- case management for the small minority of patients with highly complex and multiple conditions requiring high-intensity professional support.
- disease management for people with a complex single or multiple conditions who would need to be managed proactively by responsive specialist services
- supported self-care for the majority of those living with – or at high

risk of – long-term conditions

This is further supported by the avoiding unplanned admissions enhanced service from April 2014. The enhanced service requires practices to identify patients who are at risk of unplanned admissions and manage them appropriately with the aid of risk stratification tools, a case management register, personalised care plans and improved same day telephone access.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

The output of a recent report ran through eHealthscope is shown in Table.5 below, this details the proportion of individuals who are at high risk and whether they have already have a joint care plan in place.

Table.5 Care plan results – Nottingham City patients Summer 2014.

Number of patients & risk score	Care Plan agreed	Care Plan in development	Care Plan unnecessary	No Care plan in place
2008 – 50% or more	572	102	331	1003
3772 – 40% or more	790	126	544	2297
5221 – 35% or more	910	160	653	3498

During October/November 2014 further work will be completed through eHealthScope to produce an up to date profile of patients with care plans in place, this is will align to the risk band categories used in section 7di above. This work will support our approach to implementing the unplanned admissions enhanced service and consolidation of our aim to ensure all high risk patients have a join care plan in place.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Involvement to date

During the analysis phase of the Programme from July 2012 to February 2013, we

completed detailed engagement work with citizens and carers to understand the issues, concerns and strengths of the current health and social care system. We have used the key messages to shape our integrated care model which is now being implemented in Nottingham City with on-going newsletters and documentation keeping stakeholders updated with progress.

We have developed an engagement plan to ensure that citizens are involved in decision making throughout implementation of the programme, including discussions with 'Healthwatch' Re: mechanisms to support the on-going planning processes.

Discussions have been held with HWB3 – the VCS engagement mechanism of the Health & Well-being Board – in relation to the objectives of the Nottingham BCF, the additive elements and how the VCS can be better involved in the Integrated Care programme moving forward.

In addition as part of our role in developing the South Notts Transformation Plan we have worked with the three South Nottinghamshire CCGs since September 2013 to carry out a large-scale "Call to Action" engagement exercise involving citizens, the public and partners in how the NHS should respond to meet the challenges of the future. There have been more than 40 events and this significant engagement with a wide range of individuals with different experiences of health and social care has helped inform the debate as to how health and social care services can make bold change. At the end of January, one such exercise engaged over 130 patients.

The engagement team within the CCG have set up quarterly meetings with Age UK commencing in August 2014 to strengthen the relationship and to ensure we can regularly meet those citizens that are hard to reach. In April 2015, there will be a creation of patient diaries. Patients with long term conditions will be recording their journey and experience over a year; it will detail all the services that they have encountered along their care pathway and their experience of those services. This may highlight any gaps in service provision and ensure changes are made.

We also have membership with the Third Sector database (http://www.bvscthirdsectordatabase.org/) which lists all third sectors and self-help groups. It has the facility to be filtered down so that all groups that are relevant to older people can be targeted directly, whilst cross referencing with other protected characteristics and long term conditions to ensure the right groups are targeted.

Involvement on an on-going basis

As an on-going platform we have Nottingham City Voices (http://www.nottinghamcityvoices.org/), which is a membership network that anyone living in Nottingham City or registered with a Nottingham city GP practice can join. There is a section where residents can find out about the current and future engagement activity that they may want to be involved in. It also includes the impact of feedback and how it has been used to influence health and social care services. There is also a social media presence with a live twitter feed @NottmCityVoices which sends out tweets about any engagement activity.

To support our on-going understanding of the patient voice we have tailored our patient experience metric (template 2) to evaluate the how well patients feel supported to manage their long-term conditions. Direct feedback from patients and carers will be collected via six-monthly postal surveys mailed out by Nottingham City Council and our main community services provider Nottingham CityCare Partnership to a sample of their service users with more than one long term condition. We will establish a baseline during October/November 2014 which can then be used going forwards to evaluate the impact of interventions through the BCF Schemes.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Nottingham city has one main acute provider trust – Nottingham University Hospital Trust (NUH)

NUH are represented on the Integrated Care programme Board and have been involved in our plans for integration over the last two years. The Integrated Care model was presented at a NUH directors meeting in 2013 to support discussion's on the impact of the proposals. Full engagement re: QIPP plans including the BCF element of QIPP have taken place through NUH contract negotiations.

The Contract Clinical Board (CCB) exists as a sub-group of the Nottingham University Hospitals Contract Executive Board (CEB) and forms part of the collaborative commissioning arrangements between commissioners and Nottingham University Hospitals NHS Trust (NUH).

The purpose of the group is to provide advice and clinical oversight on cross boundary projects and pathways agreed around planned care for primary, community and secondary care. In particular, projects agreed will be aligned to discussions arising from the CEB and should be linked to each CCGs strategic priorities. Other projects arising from various forums across CCGs and NUH may also be brought for discussion and agreement as and when required. This will be used as a forum to discuss the impact of the BCF.

The South Notts Transformation Board and the System Resilience Group have oversight of local plans for integration and both have representation from NUH.

ii) primary care providers

Nottingham City has 62 GP practices; in January 2014 all practices attended Care Delivery Group (CDG) launch events; these events covered

- our approach to integrated care
- the primary care vision and the links to the integrated care strategy
- the role of primary care in the multi- disciplinary team

Primary care is represented at the commissioning executive group, CEG, which has oversight of the BCF and the Integrated Care Programme Board which has oversight of transformation activity.

Primary care representatives (GPs, practice managers and practice nurses) are also members of the work groups of the Integrated Care Programme to ensure any impact on primary care is considered in the development of new ways of working.

iii) social care and providers from the voluntary and community sector

Social care is represented at the Integrated Care Programme Board as well as at the operational planning groups to implement service integration. Comprehensive engagement with social care has ensured that Implications of BCF delivery fully understood and supported. This is reflected through the introduction of service specifications with KPIs to monitor service delivery against BCF metrics.

The voluntary and community sector are represented at the Integrated Care Programme Board by the third sector representative of the Health and Wellbeing Board. Engagement in the analysis phase of the Integrated Care Programme included hosting an event for third sector organisations to get their views on integration. Ongoing involvement includes representation on planning and implementation groups.

Discussions have been held with HWB3 – the VCS engagement mechanism of the Health & Well-being Board – in relation to the vision and objectives of the Nottingham BCF and how the VCS can be better involved in the Integrated Care programme moving forward. VCS representatives are members of the Integrated Adult Care Co-ordinated Care Steering Group and the Self Care task and finish group which is chaired by the Director of Self Help Nottingham. These mechanisms will provide the on-going vehicle for future VCS engagement in the further development of the Integrated Adult Care Programme and BCF Plan.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Nottingham City has one main acute provider hospital:

- Nottingham University Hospitals NHS Trust – NUH; operating from two sites in Nottingham

NUH is an active partner in the development of short, medium and longer term plans and has engaged in the leadership of the strategic priorities for integration. NUH have provided a statement of support around our plans included in Annex 2.

The identification of schemes has been based on the use of benchmarking information, evidence from other health communities and an inherent knowledge of existing pathways as well as an understanding of the health needs of the local populations. External consultants, Mckinseys have been commissioned to review alignment between current CCG QIPP plans and NUH finance and activity modelling. Emerging findings suggest that the plans appropriately target areas where the impact will be greatest.

The current QIPP schemes address the need to reduce avoidable hospital emergency admissions, prevent inappropriate attendances to A&E, reduce unnecessary elective referrals and improve the outcome and experience for patients through the reduction in lengths of stay etc. A number of these QIPP schemes will contribute towards the successful achievement of the BCF ambitions. This process has enabled commissioners to mitigate the risk of any double counting between QIPP and BCF schemes.
The consequence of the planned changes described will be less reliance on secondary care.

The scale of the transformational and financial challenge that the BCF process presents to the Trust is accepted along with the part it must play in delivering changes to its own services and ways of working, including reducing the size of the acute footprint.

Impact of other BCF Schemes locally

There will be an impact on NUH from the Nottingham City BCF, Nottinghamshire County BCF, and Derbyshire County BCF. Collaborative working with the South Notts Transformation Board will ensure a robust approach to achieve the reductions required in secondary care activity.

As part of the analysis supporting the development of the South Nottinghamshire Transformation five year strategy, the process continues to triangulate Commissioner QIPP and NUH CIP plans against BCF schemes so that benefits align. Baseline activity levels have already been agreed between the CCG Consortium and NUH. Work has been completed to confirm the projected activity levels and the impact within the available resources.

Further work across South Nottinghamshire is taking place to understand the capacity and capability requirements for future provision. This work indicates that there will be a reduction on occupied bed days, number of acute level beds and an increase in community based services closer to/or at home.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
1.
Scheme name
Programme Management
What is the strategic objective of this scheme?
To provide leadership and coordination of the transformation activity across health and social care, including project management for specific work areas e.g. assistive technology.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The successful implementation of complex change requires senior level support, high level co-ordination and oversight and programme and project management resource. A new post has been created to work across health and social care. The Assistant Director of Transformation will be responsible for leading on the strategic direction of adult health and social care services to ensure delivery the Better Care Fund plan which incorporates the integration agenda. This will involve working closely with NHS Nottingham City Clinical Commissioning Group and Nottingham City Council in the progression and monitoring of the Transformation Programme. The role is strategically responsible for aligning the Better Care Transformation Programme across the Nottingham City health and social care system by setting strategic direction, monitoring outcomes, monitoring performance and managing cross border external dependencies and risks. This post will be responsible for setting up and leading the governance approach to Better Care Transformation Programme, by providing strategic direction to senior commissioners to ensure whole health and social care operational management aligns with transformation strategic objectives. Project management support will be secured as required to deliver on the priority areas of the transformation agenda; this currently includes the project manager for Assistive Technology.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and

providers involved

The Assistant Director of Transformation will be employed by Nottingham City CCG, a joint approach to recruitment, supervision and PRDs will be agreed with Nottingham City Council.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

We believe that strong leadership is required to deliver a large scale change programme for a number of reasons and that a dedicated joint post to manage this is essential.

1. – Leadership is key to Integration. The Local Government Association (LGA) review of Integrated Care evidence (2013) highlights that there is overwhelming agreement that building a shared vision and goals across different providers or teams and establishing shared, trusted and respected clinical leadership is key to successful integration.
2. – Complexity of integration. Integration through BCF Schemes could involve horizontal and vertical integration, both real and virtual at different scales. For instance, within the schemes identified there will be horizontal integration such as the joint commissioning of an urgent care service (crisis response).
3. - Persistence and remaining faithful to the vision of improving outcomes is required. Effecting change across public services takes time and requires persistence to overcome barriers and challenges. It is our intention that by creating a joint post across the CCG and Local Authority we will create a strong leadership base to engage staff across organisations and facilitate transformation.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

This is an enabler to delivery of the Better Care Fund schemes.

Introduction of a joint post working across the CCG and Nottingham City Council will provide an opportunity to positively impact on the culture change required to support a joint commissioning approach.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Joint arrangements for recruitment, supervision and PRDs will ensure that the outcomes expected from the post are being realised for both organisations. The external evaluation of the integrated care programme will consider the effectiveness of the integrated care programme approach which will shape future decisions re: implementation.
What are the key success factors for implementation of this scheme?
• Robust governance arrangements to support BCF implementation will be in place. The Health and Wellbeing Board will be fully informed and updated re: progress of the Better Care Fund plan. • All corporate business returns in response to national queries and submissions to local, regional and national teams are delivered on time • Strategic plans will be delivered across organisational boundaries • The development and sustainability of the transformation will be strategically led, with interdependencies and major gateways highlighted as appropriate • Strategic input at the interface between local Authority, Clinical Commissioning Groups and Acute provider work programmes will be managed, ensuring all stakeholders are informed and guided to meet transformation objectives. • Collaborative working relationships across organisations will be established to ensure the direction of transformation is aligned to the South Notts transformation board.

ANNEX 1 – Detailed Scheme Description

Scheme ref no.
2.
Scheme name
Access & Navigation
What is the strategic objective of this scheme?
The strategic objective of this scheme is to maximise the number of citizens being directed to the right services at the right time to meet their needs. This is through a single front door accessed irrespective as to whether the citizens needs are health or social care, whether a professional or citizen is making the referral / enquiry and whether the referral / enquiry is urgent or non-urgent. This scheme addresses one of the integration priorities set out in the Vision for Health and Care Services – “Access to and navigation of service provision”. Through this scheme citizens will find that “access to services will be less complex through

single points of access and use of web-based information allowing self-access". In the Case for Change having a single point of access as well as streamlining referrals from acute to community are two of our shared ambitions for the future. This Access and Navigation scheme will contribute towards achieving that ambition.

The scheme also supports the Independence Pathway element of Adult Integrated Care in Nottingham. This scheme also supports the "Choose to Admit Transfer to Assess" programme – a southern countywide Frail Older People programme to prevent avoidable admissions and support timely discharges.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Nottingham CityCare Partnership and Nottingham City Council have operated separate Single Points of Access (SPA's) for their services for some years. In 2013 these were combined into the Nottingham Health and Care Point – a single phone number with 5 options to select for social care or health services. This was the "creation of a telephone number for citizens requiring health and care support" as set out in the Nottingham, Health and Wellbeing Strategy. In effect though Nottingham City Council and CityCare Partnership still operate their phone options as separate services with different locations, opening hours, response times and alternative access types e.g. fax, online form, email, etc. Also in many ways the different options act as a referral portal with citizens being directed to services requested as opposed to those which are suitable for need and based on availability.

This scheme will support the integration of front door **access** to social care and health services and **navigation** through to appropriate services delivery. This will be delivered by Nottingham CityCare Partnership and Nottingham City Council, supported by NHS Nottingham City CCG. The aim is to reduce the number of access options through the Nottingham Health and Care Point to simplify the process for citizens and professionals to get directed to Independence Pathway services (Scheme ref 7) appropriate for need and availability. This will be an integrated response to support citizens accessing the right level of support at the right time.

This scheme will initially see the 5 current options reduced to 3 for:-

- ➔ Urgent services (health and social care) – Community Triage Hub
- ➔ Non urgent services (health and social care)
- ➔ Non Independence Pathway health services

The Community Triage Hub is a service commissioned to support the smooth discharge for patients from hospital into the right services they need for on-going care. This is both for front door and back door discharges. The secondary Care Coordination (discharge) Team refers patients to the Community Triage Hub to ensure timely discharge from hospital to the right services for their needs. This will

become part of the Urgent services Option.

Staff on the new Health and Care Point Options will triage the requirements of citizens being referred to ensure they are signposted to the right service delivery within the Independence Pathway to suit their need, also taking into account current service availability. There will longer opening hours, consistent working practices, greater knowledge and flexibility of staff to maintain response times. This will see the Nottingham Health and Care Point as a distinct unit rather than a collection of different phone options. Staff will be working to a single job description and be trained and knowledgeable in all areas of work so provide flexibility across the 3 options. The volume of citizens requiring health and social care services is set to increase over years as set out in the Case for Change. A single Health and Care Point with flexible working and longer opening hours will be better able to accommodate the increase in volume and potential complexity of citizens requiring access to services.

Having simple and quick access will encourage use of the Health and Care Point as the central point to access services rather than trying to access services directly. This will support the effective commissioning of services in the future based on need for services delivered in an integrated way rather than maintaining existing services.

As the single enquiry and referral point for social care and health services it will cater for all ranges of adult citizen cohorts in the City. The main cohort of citizens to be targeted will be patients requiring urgent care through “Choose to Admit and Transfer to Assess”. This will be to ensure those citizens requiring discharge from hospital (front or back door) as well as those citizens at risk of hospital or care home admission will be triaged and referred through to the right urgent care services. Citizens not requiring urgent care will also be triaged with an aim to support as many as possible to be able to self-care to maintain their independence. Where citizens may need some support to regain independence they will be supported through Reablement or a Community Bed as part of the Independence Pathway.

The first phase of Access and Navigation aims to be operational from April 2015 reducing the access options from 5 to 3 and streamlining the types of enquiries and referrals to fit the Independence Pathway model of services. The second phase later in 2015 will see greater working flexibility within the access options through a single job description and extended opening hours. In the longer term other access points to services will aim to be brought into the Health and Care Point to further streamline access to services. This could include mental health, childrens and even the voluntary sector.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Separate reports within Nottingham City Council and CityCare Partnership were produced in order to create their Single Points of Access. Leading up to the creation

of the Nottingham Health and Care Point in 2013 the commissioners within NHS Nottingham City CCG and Nottingham City Council worked with the providers of CityCare Partnership and Nottingham City Council. These same commissioners and providers are currently involved in working towards the streamlined Health and Care Point required for the implementation of the Independence Pathway.

Access and Navigation is a specific project within the Adult Integrated Care Programme with different implementation phases. The Project Lead within NHS Nottingham City CCG is working with officers from Nottingham City Council and Nottingham CityCare Partnership (as providers) in a Task and Finish Group. An Options Appraisal was approved by commissioners and providers and Project Plan developed setting out the different phases will be implemented. The Group reports to the Independence Pathway / Coordinated Care Steering Group with issues and risks being presented to the Integrated Care Programme Board.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

This scheme has been selected and designed because there is local support for an integrated front door both from an organisational perspective as well as from a staff and customer perspective. The scheme design whilst not being based on formal evidence has been designed to meet the need for the triaging of citizens needs and directing them to the appropriate Independence Pathway services.

An initial meeting was held in August 2012 saw CityCare Partnership and Nottingham City Council coming together to discuss integration of access points with CCG support. The vision of a single front door was accepted though may be achieved in different stages and the different elements were set out.

An Adult Integrated Care staff engagement event in January 2013 saw this as an opportunity – “Create a single point of access to health, social care and voluntary sector”. It was also suggested that incorporating access to the voluntary sector would initially be seen as a signposting role, but longer term could be brought into the Health and Care Point.

Because of the different operating models, response times and opening hours there are also different satisfaction rates with the current options. The City Council social care option is currently able to deal with 60% of callers – citizens and professionals. This is either through level of staffing available, current operating hours or other factors. This has inevitably led to a level of dissatisfaction with access to social care. With professionals this has evolved into methods of by-pass – how to access social care services without using the Health and Care Point option. This means that triaging is not able to be done to ensure the right services are accessed and citizens can be referred for services with long waiting lists.

The evidence from current operation is that there is a degree of confusion with the

current access options as to which options should be pressed. This leads to citizens being passed between options which can lead to delays and / or citizens being asked to give details more than once.

The current Health and Care Point options were established based on services operated by the providers Nottingham City Council and CityCare Partnership. What is needed is front door access which will navigate citizens to the right Independence Pathway services based on their need and service availability, or for the citizen to be supported to be able to self-care. This is whether the citizen's needs are urgent or not.

As the Independence Pathway becomes fully integrated there is a need to be able to demonstrate which services are required and should be commissioned going forwards. Currently service provision and referrals to services is based upon the access option selected with citizens being directed to that organisation's services. Having a Health and Care Point which is triaging and directing to health and social care services they actually need, with an emphasis on promoting independence and self-care, will mean future commissioning of services will be based on need.

Investment requirements

(Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan)

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The outcomes of a centralised Health and Care Point for citizens will see them being directed to the right services for their needs based on current capacity. The outcomes for service provision will be stability by having a single referral source. This will also enable effective commissioning of services moving forwards based on need rather than services being provided because they always have been and citizens are referred to them because they ask to be.

We also expect that by directing citizens to the right services for their needs we will alleviate pressures within the system which in turn reduces delays in the transfer of care from acute settings to the community.

There has been some scoping of existing service provision leading up to the design of this scheme. Clearly there are elements of confusion with citizens and even some professionals as to which access point they need to go through for their circumstances. There is a good level of informal cooperation between current options which prevents citizens being bounced back or repeating their stories if accessing the wrong option. The staff have indicated that having clear criteria of need, fewer options and clear communication as to which option to access will reduce citizen and professional confusion.

Further detail on the impacts of this scheme can be accessed in attachment 04 – BCF Benefits Realisation Plan. A specific benefits realisation plan group has been established, this will expand to include financial impact and modelling to support the monitoring of the savings of BCF schemes. This group will continue to develop the modelling work initiated to complete the benefits plan tab 4 in template 2.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The current access options for Nottingham City Council and CityCare Partnership understand satisfaction levels through feedback and complaints analysis. There is also analysis of statistics created through the phone system which is able to demonstrate call handling performance – indicating which phone options are performing better than others.

The new Health and Care Point access options will also be performance managed – recording levels of calls dealt with, waiting times and the level of lost calls. There will be analysis of enquiry and referral types i.e. urgent and non-urgent to ensure staffing levels and skill sets are appropriate for the type and volume of calls. The flexible working arrangements will support this. Staff at the Health and Care Point will be triaging citizens and navigating them to the Independence Pathway services they need based on a criteria of need (taking into account capacity levels). Feedback will be sought from the Independence Pathway services to ensure there is satisfaction with the appropriateness of referrals and any areas for improvement.

Adult Integrated Care has initiated a 2 year evaluation of the effectiveness of the Programme covering impact on service levels and outcomes for citizens. Access and Navigation will be included in this evaluation measuring the effectiveness of the new Health and Care Point delivery. On-going feedback will also be sought from professionals and citizens using the front door for referrals and enquiries as well as feedback from the services where citizens are navigated to. One key measure of success will be to ensure that all referrals and enquiries are channelled through the Health and Care Points and that alternative / back door referral routes are not required.

In considering the viability of increasing the services being accessed through Health and Care Point discussion and consultation will need to take place with a number of agencies. For example the Health and Wellbeing 3rd Sector Forum and Self Help Nottingham about the effectiveness of signposting through to voluntary sector agencies and the possibility that the Health and Care Point could act as the access point for those agencies.

What are the key success factors for implementation of this scheme?

There is a history of partnership working between commissioners and providers in Nottingham and this is evidenced by the creation of the existing Health and Care

Point from the City Council Single Front Door and the CityCare Partnership Single Point of Access. This was driven from a desire for a single access point for health and care services and less complexity in the system. There is also evidence of collaboration between the current access options in that they have developed informal referral processes between each other where a citizen finds themselves accessing the wrong option.

In considering the phases of this scheme and the success factors for implementation this local partnership working and desire for less complexity have been taken into account. There has been a great deal of engagement undertaken between partners within the Adult Integrated Care Programme to consider how best to improve access to services and this scheme is a result of this engagement.

Success Factor	**Process**	**Timeframe**
Health and social care Reablement and urgent care services are aligned	Gain understanding of business processes across organisational boundaries and agree joined up processes where appropriate.	By April 2014 – achieved
Increased performance at existing access points	Through smarter working and increased staff resources bring up existing access point levels to consistently high levels.	July 2014 – January 2015
Initial phase new 3 option Health and Care Point established	Keeping staff working within existing options create Urgent / Non-urgent access options. Increase skill mix and access to systems. Provide additional resources to maintain workflow / service operation through transition period.	September 2014 – March 2015
Expansion of Community Triage Hub	Additional clinical resources to improve the triaging and forwarding of hospital discharge patients through to the right Independence Pathway services.	October 2014 – March 2015
Professional and citizen confidence in new Health and Care Point	Set out communication strategy to promote new Health and Care Point options. Provide stats and good news stories to re-enforce use. Close down options for direct referrals outside of the Health	February – September 2015

	and Care Point.	
Final phase of 3 option Health and Care Point	Analyse workflow from existing access options to determine resource requirements for 3 new options. Develop single job description for staff working at Health and Care Point to increase flexible working across options. Increase opening hours for those access points currently offering a 9 – 5 service.	April – October 2015
Further streamlining of access points	Review other access points, access to voluntary sector to ensure areas of overlap or duplication are reduced.	June 2015 – March 2016
Further rationalisation of HCP Options	Potential for 3 HCP's to be reduced to 1 answering all types of call.	2016 - 2018

ANNEX 1 – Detailed Scheme Description

Scheme ref no.
3.
Scheme name
Assistive Technology
What is the strategic objective of this scheme?
The strategic objective of this scheme is to maximise the use of Assistive Technology across social care and health to promote and maintain independence and health; to enable citizens to self-care where possible or to support citizens where needed. The Vision is to create an integrated Assistive Technology Service which encourages joined up equipment solutions dependent on a citizen's needs. This supports the Vision for Health and Care Services to realise the benefits of whole system model transformation including "further access to the assistive technology service". In addition this scheme supports the Nottingham City Joint Health and Wellbeing Strategy aim to "put more technology into people's homes to support them and their carers". The scheme fits with the CCG Commissioning Strategy priorities around long term conditions and improving the health and wellbeing of the frail and elderly, and the local authority Vulnerable Adults

Workforce Development priority of Joint Working to drive collaboration, integration and efficiencies.

This scheme also supports the NHS England strategy to develop Technology Enabled Care Services.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

This scheme will encourage an increased and more effective use of Assistive Technology (AT) across social care and health services and enable this to be done in an integrated way. The main forms of AT being:-

- ➔ Telecare – a range of equipment (alarms, sensors and detectors) to maintain independence, dignity and safety. Some of the equipment range is linked to a monitoring centre whereas some of the equipment range is stand alone. There are 4,000 current users of the service. Service provision includes installation and maintenance of equipment and a 7 day monitoring and rapid response service;
- ➔ Telehealth – a range of equipment to support the remote monitoring of a patient long term condition through the measurement of vital signs and other condition specific information. There are 40 current users of the service. Service provision includes installation and maintenance of equipment and 5 day monitoring of alerts;
- ➔ There is also Dispersed Alarm Provision: low intensity preventative service including 7 day monitoring and rapid response call out. Currently 2700 older citizens receive this low intensive support service a key feature of which is rapid response call out in order to reduce call out of emergency service provision.

The contracts for these services are scheduled for review in 2015.

This scheme will be delivered through an integrated Assistive Technology Service – a collaborative partnership between NHS Nottingham City CCG, Nottingham City Council, Nottingham CityCare Partnership and Nottingham City Homes. Links are also being developed with secondary care to ensure the AT Service will maximise hospital admission avoidance and support timely discharges. The AT Scheme will be available to all citizens living in the Nottingham City area who are eligible for social care services, as well as to all patients supported by health professionals who have a City GP. The development of a commercial service to sell AT equipment will also enable other citizens to be supported with equipment to increase self-care levels.

The overall aim of the scheme is to enable more citizens to remain independent, safe, supported in their own home and thus to require less interaction with health and social care services. AT is seen as a key component of the Adult Integrated Care programme – enabling more citizens to self-care and manage their condition, reducing risks and providing an appropriate response to their needs.

The specific scheme aims are to:-

- ➔ encourage greater use of AT as part of service delivery within health and social care, for AT to be used as an early intervention and prevention tool, and for specific cohorts of citizens to be supported based on need and priorities. This includes enabling a greater number of citizens to self-care with AT by development of a commercial model;
- ➔ bring together the Telecare and Telehealth services into a single AT service by April 2015 – providing a range of equipment to meet the health and / social care needs of a range of citizens. This will entail a single referral route and a single installation provider for all equipment within the service;
- ➔ link in other AT schemes and initiatives across community, primary and secondary care to ensure linkage and consistency up to 2018;
- ➔ evaluate the effectiveness of AT services on outcomes for citizens and impact on service delivery due for completion in April 2016.

The primary citizen cohort being targeted by the AT scheme are Adults with long term conditions and the frail elderly – those described as "in scope" of the Integrated Care Programme. Traditionally Telecare (including care alarm provision) has supported the frail elderly and Telehealth Level 3 patients with Heart Failure and COPD. By encouraging the early intervention and prevention agenda the aim is to widen the range of citizens being support by AT including Level 2 patients, patients with stable long term conditions managed through primary care, adults with learning disabilities and mental health issues. There is also scope to support disabled children and those moving through transition to increase their independence and minimise use of services when becoming adults. Based on the current and projected demographic population of Nottingham a target of supported 10,000 citizens through Assistive Technology has been set for 2018. This would be 8,000 through Telecare and 2,000 through Telehealth although combined packages solutions are to be encouraged.

The Long Term Conditions included in the Adult Integrated Care programme are asthma, cancer, cardio-vascular disease, chronic heart failure, COPD, dementia, diabetes, hypertension and stroke. Population figures for these conditions will be sourced from eHealthscope. The number of citizens being supported by AT are sourced from local bespoke data collection sources. The current number of AT users (4,000) represents approx. 4% of the long term condition population and 23% of patients eligible for a risk score. The aspiration of having 10,000 AT users by 2018 will see an increase to 11% of the long term condition population and 50% of patients eligible for a risk score. Statistics will be collected bi-monthly and reported to the local Long Term Conditions Strategy Group. This will help consider if those being supported by AT are those most in need / at risk. Communication, training and other awareness raising methods will be used to increase the level of citizens being supported by AT especially those with higher admission risk scores. GP practice MDT meetings will be encouraged to consider AT as part of their solutions to supporting higher risk patients, as well as increasing AT use within community nursing including for patients discharged from hospital so minimising re-admissions.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

A joint Assistive Technology Strategy was developed in 2012 called "Better Health and Well Being with Assistive Living Technology: A Joint Strategy for Nottingham City". The objectives identified through the Strategy were:-

- Improve Early Intervention / Prevention
- Sustain Independent Living
- Facilitate safe return home from hospital and other settings;
- Improve value for money;
- Improve service quality / efficiency of service providers.

These objectives were to be delivered by:-

- Integrated Adult Care;
- Joint Commissioning for an AT Service;
- Embedded AT;
- Pooled resources;
- Effective procurement;
- Change management.

An AT Project was established as part of Adult Integrated Care to deliver on the AT Strategy. This was commissioned by NHS Nottingham City CCG and Nottingham City Council. They lead providers in the delivery of AT Services in Nottingham are Nottingham City Council, Nottingham CityCare Partnership and Nottingham City Homes. There is also the support of a number of equipment suppliers. A key decision has been made that there needs to be a locally delivered and managed AT service in Nottingham rather than an equipment provider being commissioned to deliver a Managed Service. NHS Nottingham City CCG and Nottingham City Council are the commissioners of the Service (and of this scheme). Nottingham City Homes has been identified as the locally based and trusted Provider to deliver the equipment management and alert monitoring elements of the AT Service whereas Nottingham City Council and Nottingham CityCare Partnership will provide the assessment, referral, training and communication elements. NHS Nottingham City CCG will also be commissioning other related AT services for example Telemedicine and Teledermatology services.

The aim is to develop a single AT service. Steps have already been taken towards this aim with the creation of a single on-line referral portal for Telecare and Telehealth, and through Nottingham City Homes delivering equipment management and alert monitoring services for both Telecare and Telehealth. Supporting this scheme through the Better Care Fund facilitates the pooling of resources to fully integrate and coordinate service developments.

The delivery of the AT Project and Strategy is overseen by a Steering Group to drive direction and ensure outcomes are met. This reports to the Adult Integrated Care

Programme Board and ultimately to the Health and Well Being Board.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Nottingham has considered the national evidence and policy initiatives in developing its local AT services as well as learning lessons from AT delivery in other areas. This includes evidence coming from the Whole System Demonstrator (WSD) pilots, polices within the 3 Million Lives initiative, and where use of AT is referred to in other policies e.g. National Dementia Strategy. Most of all however the key evidence base has been learning lessons from local experience and listening to those who use or want to use the services. An example of national and local evidence affecting Telehealth delivery are the recent Journal of Advanced Nursing article on "The impact of Telehealth on community nursing" (http://onlinelibrary.wiley.com/doi/10.1111/jan.12480/pdf) along with a study of "nursing and community support workers experience of Telehealth (Brunel University study of Nottingham Telehealth (http://www.biomedcentral.com/1472-6963/14/164).

Following on from the Joint AT Strategy an Options Appraisal was undertaken analysing potential need for AT in Nottingham as well as access to Telecare and Telehealth services. Telecare with 4,000 current users and the dispersed alarm scheme with 2,700 users will initially be allowed to grow naturally but with a focus on non-traditional users, whereas a new Telehealth Service needed establishing and growing to 300 patients by September 2015. A business case for new investment into AT to achieve 10,000 users by 2018 will be developed in 2015. The Joint Strategy and the Options Appraisal therefore being the evidence base for the selection and design of the scheme.

Effective use of AT services enable citizens to feel more confident and in control of their condition and enable professionals to provide the right of care and support without this being too intrusive. Effective use of AT has been evidenced to help citizens remain independent in their own homes for longer and thus realise savings in the costs of service delivery. An external evaluation of the Telecare Service in 2011 evidenced that on average use of Telecare realised £1,000 in avoided costs of social care and health delivery. An internal evaluation in 2011 of Telecare users as risk of residential care placement showed that Telecare kept citizens in their own home for longer. There have been numerous studies published of Telehealth and Telecare services where cost savings have been evidenced through the avoidance of hospital admissions, reduced costs of nursing visits to patients and the delay or prevention of admission to residential care. There has been very positive feedback provided by users and carers of the Telecare Service with 96% of users feeling the equipment has given them more confidence / peace of mind and 86% of carers feeling Telecare has reduced any anxiety about the person they cared for. This is the evidence base driving the assumptions about impact and outcomes for increased use of AT across social care and health.

Assumptions have been made that citizens will embrace using AT to help them self-care and self-manage their long term condition. Assumptions have also been made that

citizens will want to be able to purchase equipment where not eligible under local thresholds. An extension of the Telecare Service will provide an equipment selling service with reasonably priced items available backed up with support to enable citizens to use the equipment effectively. These assumptions have been based on an analysis of the population profile in Nottingham as well anecdotal evidence from citizens asking where they can purchase equipment.

Having AT provision as a key element of adult integrated care, especially the Independence Pathway services, is a new area of work. Health and social care professionals working in a more coordinated, integrated way will also want to see an integrated AT Service. From April 2015 it is planned to join up the Telecare and Telehealth services into a single AT service providing a range of equipment to support a range of citizens with varying needs. Referrals will be made through a single route, and equipment installed and alerts monitored by a single provider. There has been little evidence base nationally or in other areas of AT being delivered in such a joined up way. The local AT evaluation due for completion in April 2016 should give the local evidence of the impact of this which will shape further development to 2018.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The effective use of AT can help to maintain, increase or regain a citizens level of independence in their own home, as well as supporting health, confidence, dignity and safety. In addition AT can also reduce levels of anxiety in carers about the person they care for. Therefore anticipated outcomes from an increased use of AT will be the number of citizens and carers reporting satisfaction levels with increases in levels of independence, confidence, and reduced levels of anxiety.

The integration of the Telecare and Telehealth Services into an integrated AT Service should see an increase of AT solutions managing the social care and health needs of citizens. Therefore an anticipated outcome will be an increase in packages where a combination of Telehealth and Telecare equipment is applied.

A locally developed metric (referred to in the overview) is to consider the number of people with a long term condition who are supported with AT. This currently stands at 4% of the LTC population. The target is to increase this to 11% of the LTC population by 2018, taking into account the increasing level of this population. Having 10,000 people supported by AT by 2018 is a realistic and achievable target. By comparison the estimated Nottingham portion of the 3 Million Lives initiative would be 16,000.

Further detail on the impacts of this scheme can be accessed in attachment 04 – BCF Benefits Realisation Plan. A specific benefits realisation plan group has been

established, this will expand to include financial impact and modelling to support the monitoring of the savings of BCF schemes. This group will continue to develop the modelling work initiated to complete the benefits plan tab 4 in template 2.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

There has been on-going feedback gathered from Telecare users and carers in the form of satisfaction questionnaires. In addition there have been formal evaluations of the separate Telecare and Telehealth Services.

In order to measure the outcomes of integrating the Telehealth and Telecare Services into a single Service a 2 year external evaluation of AT delivery in Nottingham has begun. The outcomes of this piece of work will shape the delivery of AT services in the future. This evaluation has the following factors:-

- ➔ a benchmark review of existing information, reports and statistics;
- ➔ interviews with key stakeholders as to their understanding and aspirations for AT – to be repeated one year later to note changes;
- ➔ AT specific questions included in a survey for frontline social care and health staff - to be repeated one year later to note changes;
- ➔ Questionnaires sent to 1,000 existing AT users and carers to gauge their views with a 10 – 20% return rate. Those returning questionnaires to be sent another one a year later to note changes;
- ➔ A cost effectiveness study of new AT users for a 6 month period (approx. 1,000) with consent being sought to obtain retrospective and future hospital, GP and social care data to view changes – a target 10% consent rate is expected;
- ➔ Outcome focussed interviews with 20 users and carers to gauge their views on how AT supports them and how it impacts on their interaction with health and care services.

Interim reports will be provided throughout the evaluation as well as a final report in April 2016. Lessons will be learnt from these reports in terms of understanding what is working and what isn't especially as the integration of AT progresses. The evaluation will evidence the contribution AT is making to the vision for health and care services including the need to reduce unnecessary hospital admissions and shorten hospital stays.

This AT evaluation will also link into and compliment the evaluation being undertaken into the over Adult Integrated Care Programme. Already this has taken the form of a staff survey including questions to address both evaluation areas.

Feedback on progress will be provided to the delivery chain for AT to ensure that strategic priorities and the aims of this scheme are maintained. Specifically this will be through the Evaluation Steering Group linking into the Assistive Technology Strategy Group, with highlight reports provided to the Integrated Care Programme Board and the Health and Wellbeing Board.

As mentioned previously uptake of citizens with long term conditions supported by AT will be reported to the local Long Term Conditions Strategy Group. The Group will be able to suggest ways to recommend AT use for specific conditions to be able to increase use within that cohort of patients.

Following conclusion of the formal evaluation local and sustainable evaluation methodology will be developed to ensure the outcomes of future AT delivery can be evidenced as to how they are addressing local health and care priorities.

What are the key success factors for implementation of this scheme?

The scheme success factors outlined below have been set out to ensure ambitious but realistic delivery of AT to support the maximum number of people with a long term condition, support integrated health and care working as well as address priorities such as reducing unnecessary hospital admissions. This has been developed following local experience and consultation, local and national evaluation, learning lessons for other areas, consideration of priorities and a partnership approach to AT delivery. This is evidenced by NHS Nottingham City NHS achieving a Highly Commended Award at the 2014 Government Opportunities Awards - http://www.goawards.co.uk/winners/

These success factors and scheme aims and deliverables have been agreed through the Assistive Technology Steering Group and endorsed by the Adult Integrated Care Programme Board.

Success Factor	Process	Timeframe
New Telehealth Service established	Equipment supplier procured. The CCG working in partnership with CityCare Partnership (community nursing) and Nottingham City Homes (monitoring centre) to develop the service to be provided – a locally managed service.	January – June 2014. Achieved.
Wider range of Telecare users	Support Telecare Service to support a wider range of citizens beyond traditional frail elderly. Production of cohort specific training and publicity materials.	April 2014 – March 2015
300 patients supported by Telehealth	Provision of training and communication to nursing teams of the Telehealth service and the benefits of supporting patients with	June 2014 – September 2015

	Telehealth. Discussions within primary and secondary care. Provision of a range of Telehealth options to support a wider range of patients.		
Agreement of future dispersed alarm commissioning intentions	Review of current dispersed alarm provision contract	July-Oct 2014	
Single Assistive Technology Service established	Single referral system already achieved. Merger of staff resources, training and communication plans, pooling of budgets.	January – June 2015	
Business case for additional AT investment	Based on the emerging evidence from the AT evaluation coupled with existing evidence, outcomes from and levels of AT use – business case needs completing to provide the level of investment required for 10,000 users by 2018.	March – September 2015	
Evaluation of AT Services completed	The AT evaluation covers various elements – stakeholders interviews, staff surveys, user / carer questionnaires and a cost effectiveness study. Interim reports will be available from which lessons can be learnt, as well as a final report.	April 2014 – March 2016	
10,000 AT users	The AT equipment range will be expanded with new suppliers to give wider choice to support citizens. Use of AT will be embedded into pathways to support cultural change so AT promoted as first choice prevention option to support citizens. The AT selling service will be operational giving access for non-eligible users.	By 2018	

ANNEX 1 – Detailed Scheme Description

Scheme ref no.
4.
Scheme name
Carers
What is the strategic objective of this scheme?
This scheme will support our vision 'to improve the experience of and access to health and social care services' through the delivery of a range of integrated and comprehensive Carers services that meet the needs of carers resident in the City in accordance with the requirements of the Care Act. The provision will enable carers to continue to provide support for as long as is practical/desirable thus reducing the need for more intensive forms of provision, including admission to residential care and hospital, enable transfer of care of citizens into a community setting as soon as they are medically stable and improve citizen experience of care. This is vital given the projected rise in numbers of citizens resident in Nottingham with long-term conditions including dementia coupled with increasing pressure on Health and Social Care budgets. The scheme is informed by the Nottingham City Joint Carers Strategy 2012-17.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The aim of the scheme is to ensure that carers are able to access the appropriate support services at the appropriate time to enable them to continue to care for family members in an independent setting. JSNA data indicates that there are 27,000 carers resident in Nottingham City (1:11 of the population) and of these 28% provide in excess of 50 hours care per week. A holistic offer of provision is planned ranging from universal advice and support to end of life respite with all Nottingham carers targeted. It is intended that appropriate provision is available to Carers as and when they require it (see delivery chain below for further detail of provision). Referral into provision will be dependent on the nature of service provided but the Community Carers Hub operated by the Carers Federation is designed to be the first port of call for City Carers in relation to understanding what services are available to meet their needs and how to access these. The Carers Hub is able to make direct referrals to the Pre-eligibility Respite Service in order to prevent an escalation of needs for those at risk of requiring a formal carer intervention. In addition Primary Care Support workers aim to raise awareness of Carers support provision

among primary care staff and carers accessing primary care.

The objective of Carers provision in the City is to ensure that vulnerable older people and those with long-term conditions are able to continue to live as independently as possible in their own homes through effective support of their carers. This is in order to prevent the need for care in a residential setting and to enable those who have required care in an acute setting to return to an independent environment when they are medically stable.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

CCG Commissioned Provision

Carers Federation*: Carers Counselling Service: providing counselling to carers to address anxiety and depression*

Crossroads Care: *Carers Respite (EoL and Dementia): provision of planned and emergency respite including sitting, overnight stays and short breaks*

Scope*: Community Rehabilitation Day Centre facility offering support, training and social activities for people with learning disabilities and their carers*

Timeout*:* delivery of culturally aware and sensitive respite care for African and African Caribbean elders and their family

Alzheimer's Society: *Dementia Support Service:* information, guidance and support to people with dementia and their carers

City Care*: Primary Care Workers:* support, information and awareness raising to carers and staff in the primary care setting

Headway*:* support, training and social activities for people with brain injury and their carers

NCC Commissioned Provision

Carers Federation: *Carers Hub: providing universal advice and support for carers residing in Nottingham City*

NCC/CCG Commissioned Provision

Carers Federation: *Young Carer: support & respite service for young carers*

Nottingham Community Housing Association: *Pre-eligibility Respite: block funded service offering respite to Carers who are pre-eligibility with access via assessment through Carers Hub*

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The evolution of provision for carers in Nottingham has benefitted from extensive co-production with Nottingham carers to develop a model of provision best able to meet their needs, ranging from general advice and support to respite provision and end of life care.

This has resulted in significant transformation in the model of delivery from 2013 the most substantive element being the creation of a Community Carers Hub delivered by the Carers Federation as the first point of contact for all City Carers. The York University 2010 meta review of Carers services indicated that the strongest evidence of effectiveness was in relation to education, information and support services, particularly when targeted.

The Carers Reference Group (incorporating carers, providers and commissioners) has led the design of the new model of provision utilising thematic groups to inform the development of specialist provision. As such the Nottingham model of Carers provision is informed by Nottingham needs. The local evidence base regarding the impact of Carers provision on BCF metrics is, however, weak. Service specifications of existing Carers provision will be refined to ensure that accurate data is recorded relating to BCF outcomes.

Better supporting carers will assist the Health and Social Care community to mitigate some of the resource pressures associated with an ageing population. In Nottingham City the over 85 population is predicted to grow by 15% in the next 6 years whilst those with long-term conditions account for 66% of current hospital bed days

There is clear evidence that a hospital stay of 3 days or longer impacts on the functional ability of frail older people (Winkleman, 2009); delivering a system to support transfer of care as soon as medically stable (i.e. when acute needs have been met), including support for carers, will, therefore, improve patient outcomes and ensure that frail older population is able to maintain their independence and live at home for as long as possible.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The Carers scheme will contribute directly to BCF Metrics relating to reduced residential and nursing care admissions by enabling more effective support for carers of those with long-term conditions. The scheme will also contribute to outcomes regarding improved patient and citizen experience by enabling residence in their own home for as long as is practical and desirable.

Further detail on the impacts of this scheme can be accessed in attachment 04 – BCF Benefits Realisation Plan. A specific benefits realisation plan group has been established, this will expand to include financial impact and modelling to support the monitoring of the savings of BCF schemes. This group will continue to develop the modelling work initiated to complete the benefits plan tab 4 in template 2.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand

what is and is not working in terms of integrated care in your area?

All commissioned provision has PI's specifically related to the objectives of that particular element of the service model and which are monitored by the appropriate commissioner. These will be refreshed so as to ensure that they cross-reference with BCF metrics.

The Carers Reference Group is the forum for on-going validation of the efficacy of the model of provision for Carers and identification of emerging trends and needs.

There is bi-annual reporting of progress against the 2012-17 Nottingham City Joint Carers Strategy to the Health and Well-being Commissioning Executive Group.

The contribution of this scheme to the delivery of BCF performance Metrics will be subject to regular monitoring at the quarterly BCF Performance Dashboard report to the HWB Commissioning Executive Group

What are the key success factors for implementation of this scheme?

Success Factor	**Process**	**Timeframe**
New Carers Hub operational	New service operational and evaluation framework in place	By April 2014 - achieved
Pre-eligibility Respite operational	New service operational and evaluation framework in place	By April 2014 – achieved
Continued support for Carers Reference Group	Provider commissioned to deliver and support Group. Thematic work streams introduced to address specific areas of carer needs	On-going
Evaluation of integrated Carers Pathway	Systemic evaluation of revised pathway coproduced with Carers and incorporating review of ability to deliver Care Act requirements. Implementation of any commissioning recommendations arising	Oct 2014 – March 2015

ANNEX 1 – Detailed Scheme Description

Scheme ref no.
5.
Scheme name

Coordinated Care

What is the strategic objective of this scheme?

The strategic objective is to provide a new model of care with an emphasis on joined up care and proactive support.

The objectives of the scheme are:

- Develop a process to identify individuals who will benefit from earlier intervention as well as those requiring support from health and social care services, building on risk stratification, risk registers and data held by relevant agencies.
- Develop training/education plans to ensure the workforce is able to deliver the new model effectively.
- Develop operational processes including care planning and case coordination to ensure effective management of individual's needs.
- Expand multi- disciplinary working to include a system of regular case reviews.
- Agree pathways and processes to ensure community resources and health promotion services are utilised effectively
- Ensure that citizens continue to be able to access quality social care provision and that there is an increased emphasis on prevention and early identification

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The model currently being implemented supports citizens with long term conditions including the frail elderly. 8 Care Delivery Groups have been established across Nottingham City which will:-

- Use a multi-disciplinary approach to care, utilising care coordinators to support clinical interventions.
- Hold regular MDT meetings to support the identification and management of citizens requiring support, including the use of risk stratification.
- Establish and maintain virtual team links to the community and voluntary sector
- Follow the principles of 'choose to admit' and 'transfer to assess' to ensure that citizens remain in their home environment wherever possible.
- Coordinate support to ensure equity in delivery of core primary care across the CDG
- Establish lead roles in the management of LTCs across the CDG
- Develop shared learning across the CDG to support the new approach to care (prevention, early intervention, MDT approach etc.)

- Deliver 7 day services to enable citizens to remain in their home wherever possible.

In scope of the coordinated care scheme are the following long term conditions: respiratory conditions, cardio vascular conditions, diabetes, neurological conditions, stroke, dementia, cancer, osteoporosis and the frail elderly (who are likely to have one or more of these conditions but may not present with a medical need as the primary reason for intervention)

The following service areas are included in the BCF:

Mental Health Resettlement Service: Short-term block funded Accommodation based service to facilitate discharge from MH acute or rehabilitation setting. The service consists of 24 hour staffed accommodation based mental health resettlement service offering short stays of up to 24 weeks to support vulnerable adults (aged 18+) discharged from inpatient mental health facilities. Entry into the service is via referral from the specialist mental health multidisciplinary team and each individual's care coordinator as part of their care plan. A minimum of 8 and maximum of 12 mixed (i.e. accessible to both men and women) self contained bed spaces and a communal area for people to socialise are provided.

The accommodation provided within this service is required to conform to Decent Homes standards[1]. In addition, the service provides resettlement support within the community to citizens moving on from the temporary accommodation to support their move to greater independence. This aspect of the service includes support throughout an additional planned period of transition to support available within the community (external to the service) for a minimum of 4 and maximum of 12 weeks on exit of the temporary accommodation, with the aim of minimising re-admittance to inpatient care.

CDG Social Work roles: posts to support reconfiguration of social care assessment to support Care Delivery Groups including risk stratification, holistic care management and development of trusted assessor models

In Reach Discharge Coordinators social work posts working across (MH) rehab and acute wards to proactively identify delayed discharges and co-ordinating early discharge plans

Mental Health Resettlement Service: Short-term block funded Accommodation based service to facilitate discharge from MH acute or rehabilitation setting

Mitigating demand pressures and maintaining eligibility at the national standard as a minimum: protection for social care services ensuring access to quality social care service provision and further development of preventative initiatives to mitigate future demand pressures

[1] Available at: http://www.communities.gov.uk/publications/housing/decenthome

Hospital Discharge Team: Hospital based social work posts delivering NCC and Health priorities re hospital discharge

7 Day Working: expansion of services to support community care at home and timely hospital discharge.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Nottingham City Council commission the mental health resettlement service from Nottingham Community Housing Association.

Nottingham City Council provides the assessment service and commissions quality social care provision to manage increased demand and deliver the national eligibility standard. The Hospital Discharge Team and MH In-reach Discharge Coordinators are part of the Adult Assessment function.

The CDG social care link work roles have been jointly commissioned.

Plans for 7 day working are being jointly developed by the CCG and Nottingham City Council.

The coordinated care project is part of the Integrated Care Programme. A steering group oversees delivery of the implementation of the model. Task and finish groups are established to support delivery of defined aspects of the model e.g. risk stratification, care coordinator role and operational processes to support MDT working; these groups have representatives from relevant stakeholders who are responsible for implementation within their organisation. Cross organisational decisions are taken through the steering group and where necessary escalated to the integrated Care Programme Board.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The literature supporting the effectiveness of integration has been reviewed in detail by The King's Fund (Curry and Ham 2010). This review concludes that the evidence is supportive of the concept of integration. The authors highlight the importance of integrating not just at the health system level, but also at the disease management and individual patient levels. The frequently cited example of Kaiser Permanente suggests that integrated care can result in fewer admissions (Feachem et al 2002). Within the Kaiser system there is a view that patients who require hospital treatment that has not been planned have not received optimum care at an earlier stage in their illness.

Transforming services for older people requires a fundamental shift towards care that is co-ordinated around the full range of an individual's needs (rather than care based around single diseases) and care that truly prioritises prevention and support for maintaining independence. Achieving this will require much more integrated working to ensure that the right mix of services is available in the right place at the right time. (The King's fund- Making our health and care systems fit for an ageing population, 2014). Early indications from the Inner North West London Integrated Care Pilot have shown that patients who had a care plan reported improved access to NHS services (64%), that they now had to spend less time booking appointments to see their GP and other health professionals (55%), and that health care staff asked them fewer questions about their medical history (67%).

There is evidence to suggest that good management of long-term conditions is ensuring that the services and support provided reflect the person's own circumstances and preferences (Coulter et al 2013). The 'house of care' model offers one approach for achieving this, where people with long term conditions engage in collaborative care planning through pre-arranged appointments, co-producing a single holistic care plan with their care-coordinator ((Coulter et al 2013). This is particularly important for older people with multiple long term conditions, since interventions and care planning approaches that focus on single chronic conditions can lead to chaotic overall care for these patients (Roland 2013)

Research by Ross et all 2011, states that case management works best as part of a wider programme to integrate care, including good access to primary care services, supporting health promotion and primary prevention, and co-ordinating community-based packages for rehabilitation and re-ablement (Challis and Hughes no date; Ross et al 2011; Goodwin et al 2012).

Seven day service provision is about equitable access, care and treatment, regardless of the day of the week. The level of service provided should ensure that the patient has a seamless pathway of care when accessing services no matter what day of the week. (NHS Services open seven days a week: Every day counts). A study published in the Journal of the Royal Society of Medicine in 2012 analysed all admissions, more than 14.2 million to NHS hospitals in England during 2009/10. It found that patients are 16 per cent more likely to die if they are admitted on a Sunday rather than a Wednesday, and 11 per cent more likely to die if they are admitted on a Saturday. Being already in hospital on a Sunday led to an 8 per cent reduced risk of dying on that day compared to already being in hospital on a Wednesday (Freemantle, N et al, 2012).

A study by the Department of Health in 2008 titled Making a strategic shift to prevention and early intervention, stated that with any change programme, making strategic shift towards prevention and early intervention requires a number of key processes to be in place. Evidence suggests that the following elements are crucial; the involvement of older people; a clear vision about the desired outcomes, effective leadership and a whole systems approach.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The scheme will support citizens to manage their own health and care needs and remain in their own homes for longer. This will result in a more informed decision making re: long term care planning and a move away from care and placements being introduced in a crisis situation. The scheme will provide an enabling role in the delivery of all BCF metrics. The MH discharge coordinators and MH resettlement service will contribute directly to DTOC metrics for those with mental health needs.

Results of the first "Integrated Care Staff Survey" (OPM, 2014) show that staff across our health and care services in Nottingham believe that the following aspects of the new ways of working through integrated care are working well and include:

- The re-establishment of **links between rehabilitation services and social care services**, as noted by Social Care Provision staff.
- Having the CDG group in place. For one Community Matron this has led to more **effective decision making regarding patient referrals.**
- Allowing Community Rehabilitation Practitioners to **work remotely from different bases**. This was felt to add flexibility to their role, while regular face-to-face meetings keep them connected to their teams.
- The **single point of contact telephone number**, highlighted by one GP for facilitating *"good communication without the need for copious paperwork".*

Through implementation of this scheme we anticipate building upon these initial successes– these ambitions are shared by our staff:-

- **Less duplication of services** resulting in *"fewer wasted visits"* for service users
- **More holistic packages of care** incorporating both health and social care services: *"Feeling that they have a team that is caring for them who all communicate with each other and are all working to the same goals".* (GP)
- **More appropriate referrals** resulting in service users receiving the most suitable care to meet their needs
- **Improved clinical outcomes** including quicker recovery and reduced hospital admissions
- **Better informed service users** who understand who is caring for them: *"[Service users] having numbers to contact if they have any issues, faces to names, and their area of work".* (Community Nurse)
- **A single point of access to care**: *"Clients will know whom to contact for further management and he/she will not have to look for different telephone*

number and contact different persons". (GP)

- **More timely care**, described as *"support being given when needed, without long waits or reaching crisis point".* (Intermediate Care Practitioner).

Further detail on the impacts of this scheme can be accessed in attachment 04 – BCF Benefits Realisation Plan. A specific benefits realisation plan group has been established, this will expand to include financial impact and modelling to support the monitoring of the savings of BCF schemes. This group will continue to develop the modelling work initiated to complete the benefits plan tab 4 in template 2.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Progress of the scheme will be monitored through the Coordinated Care Steering Group which includes provider, wider stakeholder and commissioner representation. The Steering Group reports to the Integrated Adult Care Programme Board/

An external evaluation of the integrated care programme has been commissioned and aims to answer the following questions:

- Have new pathways of care been implemented and how do they differ from the previous ones?
- Has cultural change been achieved in the workforce?
- Has workforce development been achieved to create a holistic, multi-skilled practitioner framework across health and social care?
- Do citizens find it easier to access and navigate services?
- Do citizens have improved choice and preservation of independence?
- Do citizens feel services are more joined up?
- Do citizens have improved experiences and satisfaction with services?
- Has the ICP improved health and social care outcomes?
- How do the set up and running costs compare with costs that would otherwise have been incurred?
- What savings or benefits (monetisable, quantifiable and / or qualitative) are delivered?
- How do the costs and benefits compare with stakeholder expectations?
- Who incurs the costs? And who benefits from the programme?
- What aspects of the ICP work well and why?
- What aspects work less well and why?
- How does context influence successful implementation?
- What are the lessons learnt to inform local delivery?

The methodology and data sources to complete the evaluation include stakeholder interviews, staff engagement, document review, service user engagement, service use / financial data, HES data.

What are the key success factors for implementation of this scheme?

Success Factor	Process	Timeframe
Care delivery groups operational across Nottingham city	Reconfigure community services, allocate GP practice and agree social care support to CDGs. Develop care coordinator role requirements and recruit into posts	January 2014-Achieved
CDGs are supported by skilled generalist teams with clear links into specialist support.	Review specialist services and align to CDGs as appropriate	April – December 2014
Risk profiling data is linked to additional sources of data to support proactive case finding.	Develop processes at MDTs to share information as well as explore IT developments	April 2014 – December 2014
Workforce are skilled to work proactively using a multi-disciplinary approach across organisational boundaries	Deliver a workforce training and education plan across primary care, community health and social care.	April 2014 – April 2015
Services are available to citizens 7 days per week.	Evaluate current service provision and demand outside of existing service hours. Evaluate workforce capabilities to support 7 day working. Align planning for primary care, community services and social care.	August 2014 – April 2015

ANNEX 1 – Detailed Scheme Description

Scheme ref no.
6.
Scheme name
Disabled Facilities Grant (Capital Funding)
What is the strategic objective of this scheme?
This scheme will support our vision 'to improve the experience of and access to health and social care services' by enabling citizens to receive care in their home or community. It will be utilised for preventative capital schemes including Disabled Facilities Grant and capital costs of assistive technology to promote continuation of residence in an independent setting resulting in a reduction in residential and nursing admissions and reduction in non-elective hospital admissions. The projected rise in numbers of citizens resident in Nottingham with long-term conditions including dementia coupled with increasing pressure on Health and Social Care budgets enhances the imperative for further solutions to enable citizens to reside independently in their own homes to be developed.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The scheme will provide capital funding for home adaptations through the mechanism of the Nottingham Adaptations Agency and capital funding for social care purposes to support development in three key areas: personalisation, reform and efficiency. Nottingham City Council provides a varying level of top up annually to meet the costs of the Adaptations agency above funding provided through the DFG. Referral to the Adaptations Agency is via the Social Care Occupational Therapy service. The Nottingham Adaptations Agency is consistently ahead of benchmark agencies in respect of referral to works completion times – these have reduced by 25% over the past 10 years. During 2012-13 230 private sector works were completed utilising DFG. The service has a customer satisfaction rating of 98%. The Social Care Capital grant has been utilised to meet the strategic imperative reducing the need for residential and more intensive care provision in addition to reducing non-elective admissions. During 2014/15 funding has been utilised to contribute to the capital costs of developing a new extra care scheme in the North of the City which will provide 70 units of accommodation available on a social tenure basis that will provide a real alternative to residential care. Funding has also been utilised to fund Integrated

Community Equipment provision providing aids to independent living and minor adaptations to promote independent living, prevent non elective admissions and facilitate timely discharge. Demand for the service rose by 8% during 13/14 partly as a result of increased referral through the Enablement Gateway. The Commissioning Executive Group of the Health and Well-being Board will determine the most appropriate use of capital funding for 15/16 based on priorities to deliver Better Care Fund performance metrics.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioner Nottingham City Council

Nottingham City Council Adaptations Agency: Utilisation of *Disabled Facilities Grant:* major adaptations to citizens homes to enable them to continue to live independently and reduce risk of harm

Nottingham City Council: *Social Care Capital Grant:* During 2012/13 and 13/14 capital grant funding has been utilised to fund: contribution to capital costs of developing an new extra care scheme in the North of the City, investment in assistive technology capital solutions to support independence, contribution to Integrated Community Equipment Store costs.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Adapting the homes of citizens with disabilities and long-term conditions enables them to continue living independently in their community reducing the risk of social isolation and deterioration of condition associated with a move to a different/less independent setting. It also facilitates discharge from a hospital setting and through improving the safety and appropriateness of the home environment reduces the risk of further admissions.

Research by Heywood & Turner (2007) indicated that adapting an older persons home to delay entrance to residential care can save £20,000 per annum, that the cost differential between funding an adaptation and the cost of a hip fractures is 4.7 and that adaptations to reduce the cost of homecare provision can save between £1200 and £29000 pa.

Effective use of AT has been evidenced to help citizens remain independent in their own homes for longer and thus realise savings in the costs of service delivery. An external evaluation of the Telecare Service in 2011 evidenced that on average use of Telecare realised £1,000 in avoided costs of social care and health delivery. An internal evaluation in 2011 of Telecare users as risk of residential care placement showed that Telecare kept citizens in their own home for longer. There have been numerous studies published of Telehealth and Telecare services where cost savings have been evidenced through the avoidance of hospital admissions, reduced costs of nursing visits to patients and the

delay or prevention of admission to residential care.

There is local evidence that quality effective care provision can delay or prevent access to residential care provision. A study of residential admissions from three sheltered schemes in the City (being considered for conversion to extra care) indicated that 9 admissions could have been prevented over a two year period had the accommodation been extra care.

There is clear evidence that a hospital stay of 3 days or longer impacts on the functional ability of frail older people (Winkleman, 2009); delivering a system to support transfer of care as soon as medically stable (i.e. when acute needs have been met) will, therefore, improve patient outcomes and ensure that frail older population is able to maintain their independence and live at home for as long as possible.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The Capital scheme will contribute directly to BCF outcomes of reduced residential and nursing care admissions, and reduced delayed transfers of care (see HWB Benefits Plan for detail). The scheme will also contribute to BCF Metrics concerning improved patient and service user experience by enabling citizens to stay living independently in their own home for longer.

A specific benefits realisation plan group has been established, this will expand to include financial impact and modelling to support the monitoring of the savings of BCF schemes.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Adaptations agency collates a range of performance indicators which it benchmarks against similar agencies in other localities.

A quarterly Adaptations and Occupational Therapy Consultation Group provides an ongoing mechanism for stakeholder (including citizen) input as to operational delivery efficacy.

The contribution of this scheme to the delivery of BCF performance Metrics will be subject to regular monitoring at the quarterly BCF Performance Dashboard report to the HWB Commissioning Executive Group.

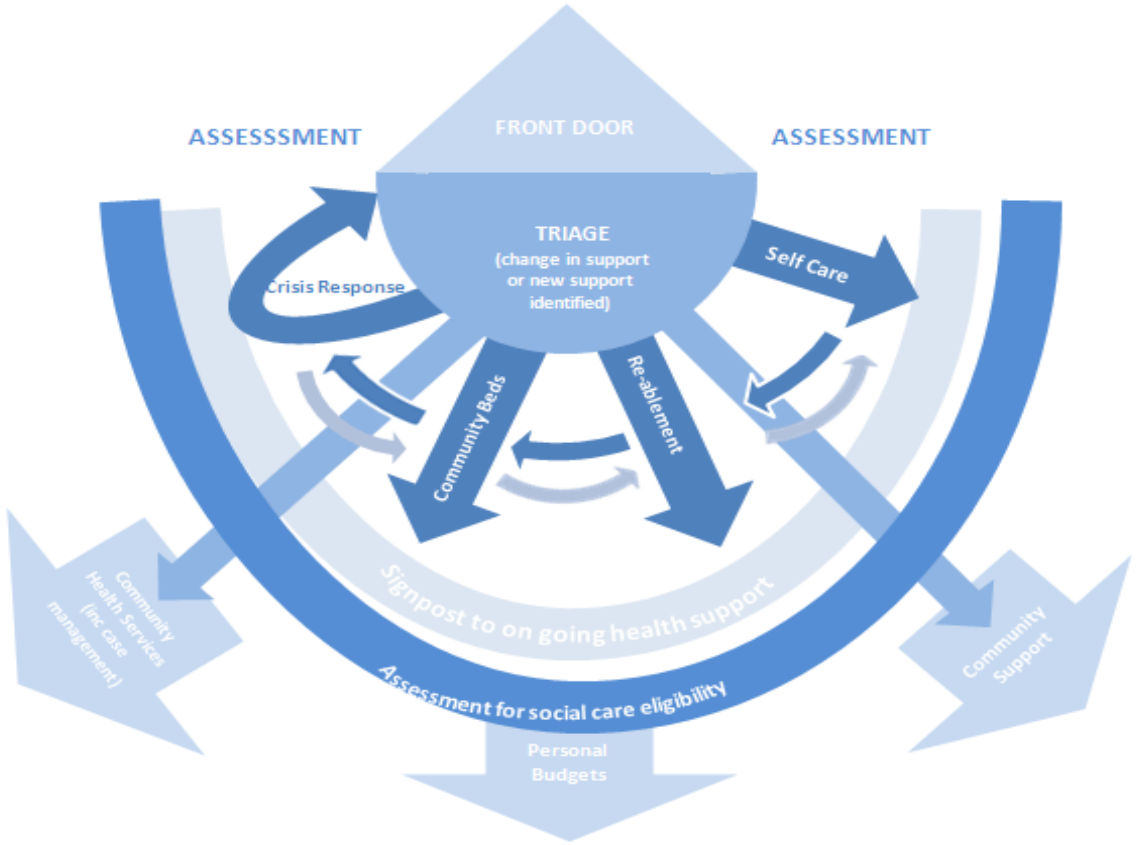
What are the key success factors for implementation of this scheme?

Success Factor	Process	Timeframe	

Adaptations targeted at those most at risk of hospital admission/institutional care	Review of current process for accessing support	By October 2014 -	
HWB Commissioning Executive Group determines priorities for capital investment in 2015/16	Review of where investment will have greatest impact on performance metrics and wider strategic priorities	By December 2014 -	

ANNEX 1 – Detailed Scheme Description

Scheme ref no.
7.
Scheme name
Independence Pathway
What is the strategic objective of this scheme?
The strategic objective of this scheme is to ensure that citizens are able to access the most appropriate short-term enablement, reablement and crisis support at the right time to remain as independent as possible in the community and to support timely discharge from acute care when medically stable The aim is to ensure that pathways into provision are simplified and that service is based on need as opposed to eligibility in order to facilitate prevention and escalation of need. Earlier identification of needs and access to a self-care pathway will ensure self-management and reduced dependence on health and social care services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme will support the integration of services to deliver a new model of assessment and rehabilitation as described below.



The services included in the BCF supporting the independence pathway model are:

- *Health Reablement Service (City Care) Intermediate Care Posts (Nottingham City Council). Offers a short term intensive period of reablement support, including clinical interventions (nursing, OT, physiotherapy) to prevent hospital admission or facilitate early discharge.*
- *Social Care Reablement service -Short term social care reablement service to increase independence prior to receiving long term service or prevent need for ongoing care.*
- *Community beds (Citycare) Short term intervention for people with more complex needs, offer assessment and rehabilitation, plans are in place to offer step up from the community.*
- *Interim beds (Ramsey Healthcare UK)*
- *Urgent response service (Citycare)Offers a 2 hour response in urgent situations, offers clinical assessment and care support where required. Transfers care within 48 hours to appropriate service.*
- *Nottingham Emergency Homecare Service (Nottingham City Council)- quick access, 48 hour duration Enablement Team (Nottingham City Council), Social care team sourcing community based care options to enable citizens to live independently without recourse to traditional care services Assessment for and securing of community based alternatives to Health and Social Care provision for those triaged through Health and Care Point*
- *Access & Rapid Response social care staff posts, including Rapid Response OT and Crisis Response to support those referred to social care with emergency*

needs and delivering NCC and Health priorities re preventing emergency admissions

- *In-Reach Discharge: specific assessment posts facilitating access to and exit from Independence Pathway Reablement and Community Bed provision*

Work has taken place over the last year to align operational processes to ensure a seamless pathway of care for patients. Further planning to fully integrate the services is taking place between commissioners with a planned implementation date of April 2016.

These services will manage the mainly frail older population to prevent hospital admission wherever possible and to facilitate timely discharge when a hospital admission is necessary.

Expansion of reablement and coordination services to deliver the choose to admit / transfer to assess model is currently being planned for implementation by October 2015. It is anticipated that frail elderly and people with long-term conditions being discharged from hospital (other than end of life) will be offered a reablement service in addition to community referrals whose needs cannot be met through the self-care pathway or who do not simply require an adjustment to their existing service package. Urgent care services will be provided within 2 hours of point of need in order to prevent hospital or residential admissions with an intended maximum support duration of 48 hours to ensure sufficient capacity in the service. Reablement and Emergency Care provision is available seven days per week with 24 hour cover being provided by the 'through the night' element of the urgent care service.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Nottingham City CCG currently commissions the Citycare services in the scheme and Ramsay Healthcare UK for the interim bed provision.

Nottingham City Council currently commissions their own provider arm services in the scheme. Access and Rapid Response, In Reach Discharge and Enablement Gateway are elements of the City Council social care assessment function.

The Independence Pathway project is part of the Integrated Care Programme. A steering group oversees delivery of the implementation of the model. Task and finish groups are established to support delivery of defined aspects of the model e.g. community beds, reablement, urgent care and self care pathways these groups have representatives from relevant stakeholders who are responsible for implementation within their organisation. Cross organisational decisions are taken through the steering group and where necessary escalated to the integrated Care Programme Board. It is intended that from 2015/16 the Health and Social Care Reablement and Urgent Care services will be commissioned as fully integrated single services for the respective pathways.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There is a good evidence base on the effectiveness of intermediate care services and hospital at home services in terms of improved patient outcomes, reduced length of stay and reduced long term care placements. The independence pathway was developed in line with the following evidence base.

Care Coordination through integrated health and social care teams. King's Fund 2011

Robust evidence on health outcomes is limited, but improved care co-ordination can have a significant effect on the quality of life of older frail people and people with multiple long-term conditions (Hofmarcher *et al* 2007).Highly integrated primary care systems that emphasise continuity and co-ordination of care are associated with better patient experience (Starfield 1998; Bodenheimer 2008).

Urgent response

There is a growing body of evidence to suggest that effective urgent response services have a positive impact on the care pathway and outcomes for all service users. Research by the Department of Health 2002 demonstrates that properly resourced and urgent response services ensure fewer people are unnecessarily admitted to hospital or residential care resulting in better outcomes for the individual and greater efficiency in the system.

An admission to hospital or care increases the likelihood that a frail older person will not return into the community. Studies from the National Audit Office 2007 (Improving services for people with dementia) show that the functioning of older people is reduced significantly within two days of being admitted to hospital, and in older people with any form of mental health need, there is evidence of increased mortality, increased length of stay, loss of independence and higher rates of admissions to care homes.

Community Beds and Reablement services

Guidance from the Department of Health, entitled Intermediate Care - Halfway Home 2009 recommends that health and local government organisations, with a shared vision, should undertake strategic planning for intermediate care jointly. The guidance recommends a core multidisciplinary intermediate care team, which is led by a senior clinician, ideally with one overall manager, and closely linked to re-ablement services in social care. The key target groups for Intermediate care, people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care, remain the priority.

Francis et al., 2011 produce a review of reablement as a cost effective route to better outcomes on behalf of the Social Care Institute for Excellence. Their review concluded that

- Reablement (at home) is significantly associated with better health-related quality of life and social care-related outcomes compared with conventional home care.
- Reablement improves outcomes, particularly in terms of restoring people's ability

to perform usual activities and improving their perceived quality of life.
- Reablement achieves cost savings through reducing or removing the need for ongoing support via traditional home care.
- Reablement had positive impacts on users' health related quality of life and social care-related quality of life up to ten months after reablement, in comparisons with users of conventional home care services.

Self Care

The evidence is clear that patients who are empowered, knowledgeable and supported, utilise services less and have better health outcomes. We used two key publications: "The Proposal for People Powered Health" Nesta and the UK Innovation unit - estimate that the NHS in England could realise savings of at least £4.4 billion a year if it adopted systematic application of strategies which involve patients, their families and communities more directly in the management of long term health conditions. These savings represent a 7% reduction in spending in terms of reduced A&E attendances, planned and unplanned admissions, and outpatient admissions.

Expert Patent Programme, 2010 showed that patients who took part in effective self-care / self-management programmes went on to use less NHS frontline services, amounting to an average cost saving per patient of around £1500 per year, every year.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The scheme will contribute directly to the BCF metrics of reduced residential and nursing admissions and more effective reablement services. The scheme will also enable the development of the BCF metrics of reduced non elective admissions, delayed transfers of care and improved patient/citizen experience of care. Most importantly the scheme will be a key factor in demand management across the health and social care system by providing appropriate support to develop citizens' confidence to maximise their independence and access support networks within the local community.

Further detail on the impacts of this scheme can be accessed in attachment 04 – BCF Benefits Realisation Plan. A specific benefits realisation plan group has been established, this will expand to include financial impact and modelling to support the monitoring of the savings of BCF schemes. This group will continue to develop the modelling work initiated to complete the benefits plan tab 4 in template 2.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

All commissioned provision has PI's specifically related to the objectives of that particular element of the service model and which are monitored by the appropriate commissioner. These will be refreshed so as to ensure that they more closely align with BCF metrics.

The contribution of this scheme to the delivery of BCF performance Metrics will be subject to regular monitoring at the quarterly BCF Performance Dashboard report to the HWB Commissioning Executive Group.

The Reablement and Self Care task and finish groups which include provider, wider stakeholder and commissioner representation feed into the Co-ordinated Care steering group which in turn reports to the Integrated Adult Care Programme Board. This provides a governance route through which the efficacy of the Independence Pathway scheme can be monitored and service developments/improvements proposed

An external evaluation of the integrated care programme has been commissioned and aims to answer the following questions:

- Have new pathways of care been implemented and how do they differ from the previous ones?
- Has cultural change been achieved in the workforce?
- Has workforce development been achieved to create a holistic, multi-skilled practitioner framework across health and social care?
- Do citizens find it easier to access and navigate services?
- Do citizens have improved choice and preservation of independence?
- Do citizens feel services are more joined up?
- Do citizens have improved experiences and satisfaction with services?
- Has the ICP improved health and social care outcomes?
- How do the set up and running costs compare with costs that would otherwise have been incurred?
- What savings or benefits (monetisable, quantifiable and / or qualitative) are delivered?
- How do the costs and benefits compare with stakeholder expectations?
- Who incurs the costs? And who benefits from the programme?
- What aspects of the ICP work well and why?
- What aspects work less well and why?
- How does context influence successful implementation?
- What are the lessons learnt to inform local delivery?

The methodology and data sources to complete the evaluation include stakeholder interviews, staff engagement, document review, service user engagement, service use / financial data, HES data.

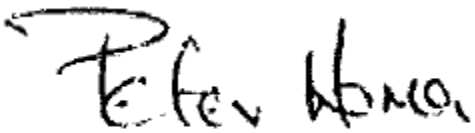
What are the key success factors for implementation of this scheme?

Success Factor	Process	Timeframe
Health and social care Reablement services are	Gain understanding of business processes across	By April 2014 - achieved

aligned	organisational boundaries and agree joined up processes where appropriate.		
'Choose to admit / transfer to assess' fully implemented	Redesign the community hub Agree new reablement model to manage a range of needs (low to high complexity) Commission additional community beds Reconfigure social care assessment to support this new approach. Review service specification for Lings Bar Hospital	July 2014 – May 2015	
Health and social care reablement services are fully integrated	Agree commissioning approach for new reablement service model	July 2014 – March 2015	
Citizens are supported to self care and maintain their level of independence to remain in their home environment.	Implement the self care pathway (signposting using agreed framework) Formalise links with the community and voluntary sector to create a 'pull' from the independence pathway services.	August 2014 – August 2015	

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Nottingham City
Name of Provider organisation	Nottingham University Hospitals NHS Trust
Name of Provider CEO	Peter Homa
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	30,489
	2014/15 Plan	29,599
	2015/16 Plan	28,563
	14/15 Change compared to 13/14 outturn	-2.9%
	15/16 Change compared to planned 14/15 outturn	-3.5%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	526
	How many non-elective admissions is the BCF planned to prevent in 15-16?	526

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	We recognise the data above however there is no account taken of the continued upward trend in non-elective activity this year since the baseline was originally set and effects on acute services of an increasing elderly population which aren't factored into the assumptions. When considering these factors we think the proposed baseline is 2.4% understated.

2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	Reasons as above which makes achieving the plan more difficult. We are part of the combined effort to maximise the impact of integrated care; at the same time we are concerned as to how risk will be managed if the schemes – which we support– do not deliver at the scale and pace required for us to reduce capacity and costs.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	The Trust recognises and supports the importance to patients and local communities of developing integrated service models which better meet their needs, and which reduce the number of hospital admissions that happen as a result of crises, that could be avoided by more proactive care in community settings. To deliver the BCF plan the Trust will continue to actively engage with other health and social care providers, focused on the development of innovative services at scale and pace. The necessity of three key factors: ambition, service change at real scale, and the need for pace of delivery: appears central to the meaningful utilisation of the BCF. We look forward to further engagement with our commissioners, other providers and our colleagues in social care regarding the careful prioritisation of investment against truly ambitious metrics for improvement. Our workforce will play their part in delivering the required change, building upon the various pathways where they already support the delivery of community based care. We are already working closely with local partners to ensure effective commissioning and development of the wider health and social care workforce, and recognise that the timely supply of this workforce is a key risk to the effective delivery of our plans. We also recognise the sale of the transformational and financial challenge that faces all of us in creating sustainable health and social care economies for the future, and in which the BCF presents an important lever. We

		absolutely accept the part we must play in delivering changes to our own services and ways of working. At the same time we would stress the very real risk that presents itself if the impact of services developed via the BCF is not sufficient to support the targeted scale of reduction in capacity and cost-base within our hospitals. This has the potential to undermine the safety, quality and accessibility of the services we offer. We share a particular concern that there is little financial flexibility to support transition between present and desired service models and are keen to understand how this transition will be managed. We are encouraged by the steps that are being taken to explore mechanisms to share risk and mitigation, and wish to see these put in place. *September 2014*