Integrated Care System
Nottingham & Nottinghamshire

Better Care Fund
Root and Branch Review

Nottingham City Phase 3 Working Group

Working group to progress the BCF root and branch review recommendations

Integrated Care System
Nottingham & Nottinghamshire

www.healthandcarenotts.co.uk @NHSNottingham

Nottingham City Homes Coordinator (Joint)
expedited advice & rehousing

Drug and Alcohol Treatment and Recovery Service

Age UK Wellbeing at Home (LA)
Volunteer-led support for tasks (shopping, cleaning, accessing activities)

Social Prescribing 1-1 signposting and referral to health, care and wider determinant services

'P3' beds long-term needs
Capacity 38 per month

Enablers (Joint)
Housing adaptation (DFGs) 210 per year, Handyperson, Community equipment
Assistive Tech (home alarms) 591 per month

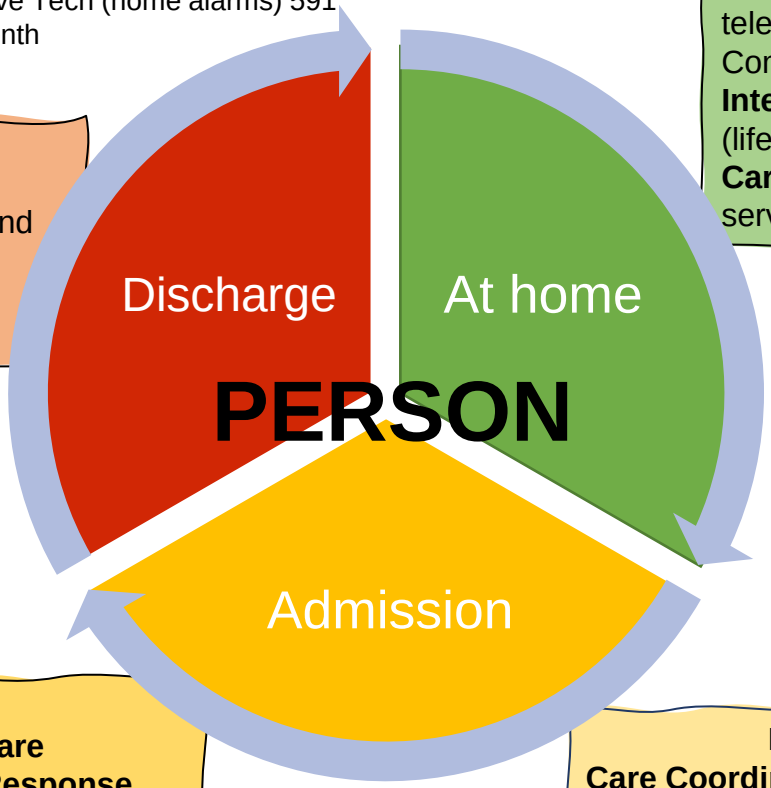
'P2 Interim beds(LA, ICB)
discharge and step up (P2) (CityCare) c.£1m
Capacity 83 per month

Prevention

Nottingham Health & Care Point single telephone contact point for ASC and Community Health services (+ASK LION)
Integrated Wellbeing Support Service (lifestyle advice e.g. smoking)
Carers Hub (Identification and support services – *200 people supported per month*

Discharge to Assess

Transfer of Care Hub
Coordination of packages of care and support for people leaving hospital
Discharge to 'home' on plan but below peer average.



Falls (ICB)
Falls bone health, rehab, physio and strength exercises
(counted in Long term conditions)
BCF data shows higher rate of falls compared to peers (although a downward trend).

Long Term Conditions (ICB) case management, community nursing, diabetes, heart failure, COPD, SMD
LTC 1,600 per month, Homeless/SMD 50 per month, rehab completion 75%

'P1' reablement at home
LA c.£4m (split admission and discharge)
LA home care c.£2.3m
Reablement (ICB)
P1 422 per month total capacity
Community 91 per month total capacity

Proactive Care

Urgent Community Response Team (2 hour crisis) home assessment (CityCare)
577 per month 2 hours and 143 per month 48 hours
% avoided admissions

Adult Social Care & Occupational Therapy assessment teams

Proactive Care

Care Coordination- risk profiling people at risk of admission and MDT meetings (GP reviews, ASC assessors, specialist nurses).
Approx. 200 per month 'at risk of admission'

BCF Identified Integration Opportunity	Reason
Prevention: Integration of lifestyle advice services (e.g. smoking) with health and care pathways	Opportunity to jointly plan (not currently in BCF plan)
Prevention: Maximising the effectiveness of a range of navigation and support worker roles e.g. social prescribing, navigators, community development workers, health coaches) including reaching health inclusion groups *See Birmingham INT case study, 'Friendship at Home NE Lincs, Croydon Independence coordination*	Opportunity to jointly plan (not currently in BCF plan), duplication of spend and contact with individuals, insufficient outcome information to understand impact, emerging evidence base/good practice
Proactive Care: Integration of MDT case management of people at risk of admission (falls, frailty and long term conditions). Holistic joined up oversight of wider needs e.g. housing and council prevention services *See Wirral Falls Review, Gloucester joint strategy*	Opportunity to jointly plan. Insufficient outcome information to understand impact
Proactive Care: 2hour crisis response (rapid clinical assessment of need at home to avoid an admission. Service liaises with services to arrange an at home package of care to maintain independence	System performance issues, integration and potential to expand approach
Discharge to Assess: 'P0' better coordination of prevention, housing and practical support services for people not requiring ASC/health reablement *See NE Lincs VCS collab, Birmingham step down housing*	System performance issues, potential duplication or poor value, emerging evidence base/good practice
Discharge to Assess: 'P1' consistent offer of reablement and monitoring of operational flow via Transfer of Care hubs. Earlier involvement in housing to reduce length of stay. Collective view of capacity, spend and market management (include homecare capacity to avoid 'bottle-necks') *See Birmingham step down housing, NE Lincs VCS collab*	System performance issues, inconsistency in offer, potential poor value, emerging evidence base/good value