

HEALTH AND WELLBEING BOARD – FEBRUARY 2014

Title of paper:	Better Care Fund	
Director(s)/ Corporate Director(s):	Maria Principe, Director of Primary Care Development and Service Integration, NHS Nottingham City Clinical Commissioning Group Candida Brudenell, Director of Quality and Commissioning, Nottingham City Council	Wards affected:
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Date of consultation with Portfolio Holder(s) (if relevant)	Cllr Norris – 13th February	
Relevant Council Plan Strategic Priority:		
Cutting unemployment by a quarter	<input type="checkbox"/>	
Cut crime and anti-social behaviour	<input type="checkbox"/>	
Ensure more school leavers get a job, training or further education than any other City	<input type="checkbox"/>	
Your neighbourhood as clean as the City Centre	<input type="checkbox"/>	
Help keep your energy bills down	<input type="checkbox"/>	
Good access to public transport	<input type="checkbox"/>	
Nottingham has a good mix of housing	<input type="checkbox"/>	
Nottingham is a good place to do business, invest and create jobs	<input type="checkbox"/>	
Nottingham offers a wide range of leisure activities, parks and sporting events	<input type="checkbox"/>	
Support early intervention activities	<input checked="" type="checkbox"/>	
Deliver effective, value for money services to our citizens	<input checked="" type="checkbox"/>	√
Summary of issues (including benefits to citizens/service users):		
This paper provides Board with context in relation to the establishment of the Better Care Fund as an enabler to deliver the integration agenda at scale and pace. It sets out national guidance and performance expectations in relation to the Fund and associated sign-off and governance requirements.		
Recommendation(s):		
1	Board approves the vision for and use of Better Care funds as detailed in the Better Care Plan template (appendix 1 and 2) as required by the NHS England Regional Team.	

1. REASONS FOR RECOMMENDATIONS

- 1.1 The Fund provides for £3.8 billion worth of funding nationally in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users and carers. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare for the Better Care Fund in 2015/16. For 2014/15 there are no additional conditions attached to the £900m transfer already announced, but NHS England will only pay out the additional £200m to councils that have jointly agreed and signed off two-year plans for the Better Care Fund (BCF).
- 1.2 The requirements for the use of the funds transferred from the NHS to local authorities in 2014/15 remain consistent with the guidance from the Department of Health (DH) to NHS England on 19 December 2012 on the funding transfer from NHS to social care in 2013/14. In line with the following conditions:
- *“The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition we want to provide flexibility for local areas to determine how this investment in social care services is best used.*
 - *A condition of the transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and Wellbeing boards will be the natural place for discussions between NHS England, clinical commissioning groups and councils on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.*
 - *In line with our responsibilities under the Health and Social Care Act, an additional condition of the transfer is that councils and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.*
 - *A further condition of the transfer is that local authorities councils and clinical commissioning groups demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer”*
- 1.3 It is a stipulation of the fund that Councils should use the additional £200m (1.292m for Nottingham City) to prepare for the implementation of pooled budgets in April 2015 and to make early progress against the national conditions and the performance measures set out in the locally agreed plan. This is important, since some of the performance-related money is linked to performance in 2014/15.
- 1.4 Appendix 1 and 2 details the Nottingham BCF in the template format that is required by NHS England. This document is required to be formally signed off by the Health and Well-being Board
- 1.5 The additive elements of the Nottingham BCF are as follows:
- Care Coordination Service to support the Care Deliver Groups
 - Expansion of Health and Care Point
 - Support 7 day working across primary care
 - Development of the Telehealth programme
 - Mental Health In-reach Discharge Coordinators

2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

- 2.1 Over the past four years, funding from the Department of Health has been passed, via local NHS commissioners (previously the Primary Care Trust, now, following NHS Reform, a combination of the Clinical Commissioning Group and NHS England Area Team). Funding streams have included: additional support funding for social care; improving and sustaining performance on access (primarily to hospital services); and reablement support. Each funding stream has typically come with guidance about use of the funding, which has informed the development of local agreements between the NHS and Local Authority about use of the funding. These agreements are termed “Section 256” Agreements as they are made under the terms of Section 256 of the National Health Service Act 2006.

Following NHS Reform, a proportion of the funding for 2013/14 is covered by a Section 256 Agreement between the Clinical Commissioning Group (CCG) and Council. In the June 2013 spending round covering 2015/16 a national £3.8 billion “Integration Transformation Fund” was announced. This fund, established by the Department of Health, is to be held by local authorities and will include funding previously transferred by local NHS commissioners to the Council under Section 256 Agreements.

Guidance on developing plans for the Better Care Fund (formerly the Integration Transformation Fund) were published by both NHS England and the Department of Communities and Local Government on 20th December 2013 along with local allocations of the first full year of the fund in 2015/16.

2.2 What is the Better Care Fund?

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

The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work Clinical Commissioning Groups (CCGs) and councils are already doing.

2.3 Nottingham City’s approach to implementing the Better Care Fund Principles

A sub group made up of CCG and LA members has been meeting on a weekly basis to agree principles that will ensure a consistent and transparent approach to the allocation of the better care funds. It was agreed that the overarching principles of the BCF should:

- Support the priorities in the Joint Health and Wellbeing Strategy as well as align with the CCG Plan, NHS England operational plan and others;
- Acknowledge the extent of integrated commissioning and service delivery already in place, and where applicable use the Fund to formalise what is already in place;
- Acknowledge that the Fund does not represent “new” money flowing into the local health and social care system;
- Utilise the Integrated Programme Board for operational systems and processes to ensure engagement and consistent feed through.

- Utilise The Health and Wellbeing Commissioning Executive Group to strategically oversee performance and outcomes of the fund.
- Work towards achieving the national metrics to:-
 - Reduce Length of Stay
 - Improve Delayed Transfers of Care
 - Reduce emergency admissions
 - Remain at home after 90 days after re-ablement

2.4 National Conditions

The Spending Round established six national conditions for access to the Fund:

National Condition	Definition
Plans to be jointly agreed.	The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups.
Protection for social care services (not spending).	Local areas must include an explanation of how local adult social care services will be protected within their plans.
As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.	Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends.
Better data sharing between health and social care, based on the NHS number.	Local areas should confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to.
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional.	Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals.

3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

- 3.1 In developing the Nottingham Better Care Fund commissioners had regard to the national guidance and expectations issued by NHS England and the agreed outcomes contained within the Nottingham Health and Wellbeing Strategy and the Integrated Care Programme. These criteria were used to inform how the additive elements of the Fund should be allocated recognising that the Fund is predominantly comprised of existing allocated funding. Despite the 'new' element of the Fund

comprising only 5% the commissioners will deliver efficiencies to enable the additive elements of the Nottingham BCF to total 18% of available funding.

4. **FINANCIAL IMPLICATIONS (INCLUDING VALUE FOR MONEY/VAT)**

4.1 **Better Care Fund - Nottingham City**

The Nottingham City Better Care Fund allocation is comprised as follows:

2014/15 – £9.8m	2015/16 - £23.2m
In 2015/16 the Fund will be created from:	
£23.2m of Health and Local Authority Funding	
£9.8m based on existing funding in 2014/15 that is allocated across the health and wider care system. This comprises of:	
<ul style="list-style-type: none"> • £800k Carers Break funding • £1.9m CCG reablement funding • £7.1m existing transfer from health to adult social care. 	
The 23.2m will comprise of:	
<ul style="list-style-type: none"> • £9.8m existing funding allocation for 2014/15 • £11.6m additional health funding • £1.8m Disabled Facilities & Social Care Capital Grant 	

4.2 The specific elements of the Nottingham Better Care Fund for 2015/16 are as follows:

Schemes:	Investments
Independence Pathway	10,060,093
Coordinated Care	8,118,690
Assistive Technology	1,145,000
Access & Navigation	1,815,852
Management	160,000
Carers	1,041,857
Disabled Facilities and Social Care Grant	1,863,000
TOTAL INVESTMENT	24,204,492

*Further negotiation required to meet 23.2m targeted expenditure, however this is expected to be delivered in 2015/16 once the budgets are integrated and duplication and excess can be identified.

5. RISK MANAGEMENT ISSUES (INCLUDING LEGAL IMPLICATIONS AND CRIME AND DISORDER ACT IMPLICATIONS)

5.1 Performance Related Pay

The Spending Round indicated that £1bn of the £3.8bn would be linked to achieving outcomes. For Nottingham City this equates to approximately £6m. Ministers have agreed the basis on which this payment-for-performance element of the Fund will operate.

Half of the £1bn will be released in April 2015. £250m of this will depend on progress against four of the six national conditions and the other £250m will relate to performance against a number of national and locally determined metrics during 2014/15. The remainder (£500m) will be released in October 2015 and will relate to further progress against the national and locally determined metrics.

The (national) performance payment arrangements are summarised in the table below:

When:	Payment for performance amount	Paid for:
April 2015	£250m	<ul style="list-style-type: none"> • Progress against four of the national conditions: • protection for adult social care services • providing 7-day services to support patients being discharged and prevent unnecessary admissions at weekends • agreement on the consequential impact of changes in the acute sector; • ensuring that where funding is used for integrated packages of care there will be an accountable lead professional
	£250m	Progress against the local metric and two of the national metrics: <ul style="list-style-type: none"> • delayed transfers of care; • avoidable emergency admissions; and
When:	Payment for performance amount	Paid for:
October 2015	£500m	Further progress against all of the national and local metrics.

5.2 Nottingham City Better Care Fund metrics

The following table details the performance aspirations for Nottingham against each of the agreed national metrics. These targets have been developed based on guidance issued by NHS England and are subject to approval by the Regional Team

NHS Outcomes Framework	
Metrics	How we will measure this
<ul style="list-style-type: none"> • 4% increase of people feeling supported to manage their (long term)condition 	<ul style="list-style-type: none"> • Non-elective admissions aged 65+ per 1,000 pop 65+ • Non-elective bed days aged 65+ per head of

<ul style="list-style-type: none"> • 13% Reduction in admissions to residential and care homes; • 6% increase in the effectiveness of reablement; • 5% Reduction in delayed transfers of care; • 10% Reduction in avoidable emergency admissions • Patient Experience metric (TBA). 	<ul style="list-style-type: none"> • 1,000 pop 65+ • Non-elective re-admission rate within 30 days • Non-elective re-admission rate within 90 days • Excess winter deaths for over 65s • No of delayed transfer of care days aged 18+ per 100,000 pop • Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation • Proportion of people aged 65+ discharged direct to residential care • Outcome of short-term support to maximise independence for new and existing clients (STS002a/b) • Permanent admissions to residential / nursing care aged 65+ per 100,000 pop 65+ • Count of clients receiving long-term services (LTS001a)
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5.3 To ensure that the performance expectations are delivered a performance dashboard will be created and monitored via the Health and Wellbeing Commissioning Executive Group (HWBCEG). A joint programme Manager post will have the responsibility for ensuring the necessary performance and outcomes are delivering against the agreed metrics, with the HWBCEG providing oversight and guidance, feeding into the Health and Wellbeing Board through quarterly reports.

5.4 **Timescales:** the following needs to be adhered to in order to meet NHS England deadlines for submission of plans and release of additional 14/15 allocation.

- February 14th: Submit 1st draft to Area Team
- February 26th 2014: Sign off by Health and Wellbeing Board
- March 12th 2014: Nottingham City Council Executive Board Commissioners Sign off
- 4th April 2014: Submit plans

6. EQUALITY IMPACT ASSESSMENT

Yes – Equality Impact Assessment attached – Appendix 3

Due regard should be given to the equality implications identified in the EIA.

7. LIST OF BACKGROUND PAPERS OTHER THAN PUBLISHED WORKS OR THOSE DISCLOSING CONFIDENTIAL OR EXEMPT INFORMATION

None

8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

The link to ‘Everyone Counts: Planning for Patients 2014/15 to 2018/19’ document is below:

<http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf>



Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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
Clinical Commissioning Groups	NHS Nottingham City
Boundary Differences	Boundary is coterminous with the City Council
Date agreed at Health and Well-Being Board:	26th February 2014
Date submitted:	14th February 2014
Minimum required value of ITF pooled budget: 2014/15	£10.01
2015/16	£24.0
Total agreed value of pooled budget: 2014/15	£24.0
2015/16	£24.0

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dawn Smith
Position	Chief Operating Officer
Date	

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

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Alex Norris
Date	

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it.

BCF funds now form part of the Integrated Care Programme which has senior sponsorship from Ian Curryer Chief Executive Nottingham City Council, and Dawn Smith, Chief Operating Officer NHS Nottingham City CCG. To ensure operational compliance health and social care providers are involved with this programme via the following groups:-

- The Health and Wellbeing Board
- Health and Wellbeing Commissioning Executive Group (CEG)
- Weekly Better Care Funding sub groups
- The Strategy and Implementation Group for Nottinghamshire South (SIGNS)
- The Urgent Care Board
- The Collaborative Commissioning Congress
- The Integrated Care Programme Board

The Integrated Care Programme aligns with the national agenda for integrating health and social care in which Nottingham City stakeholders and citizens have come together to develop a local vision and programme structure, overseen by a joint board comprising of executive leads from both provider and commissioning organisations under the scrutiny and oversight of the Health and Wellbeing board.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it.

During the analysis phase of the Programme detailed engagement with citizens and carers took place to understand the issues, concerns and strengths of the current health and social care system. This information was used to shape the integrated care model which is now being implemented with on-going newsletters and documentation keeping stakeholders updated with progress.

An engagement plan to ensure that citizens are involved in decision making throughout implementation of the programme is now in place with discussions underway 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

e) 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.

Appendix 1

Document or information title	Synopsis and links
Integrated Care Programme Plan	Detailed Programme plan describing the new model of integrated care and the projects established to deliver the vision.
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
BCF Reconciliation Plan	Provides detailed breakdown of projects.

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our Vision is to improve the experience of and access to health and social care services for citizens. More citizens will report that their quality of life has improved as a result of integrated health and care services. The number of citizens remaining independent in the community, including after hospital admission will increase with improved and seamless transfers of care.

To deliver this vision we will undertake an extensive system wide Programme of change that will see local services reshaped to deliver joined up care. The emphasis 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.

The changes will involve the following:-

- Agree the configuration of Care Delivery Groups which incorporates groups of GP practices.
- Reconfigure community services to establish neighborhood care teams that work within the care delivery groups.
- Reconfigure primary care services to share clinical and back office functions
- Reconfigure social care assessment to support the Care Delivery Groups.
- Reconfigure intermediate care services, crisis response and LA reablement and emergency home care services to support independence pathways.
- Align specialist LTC support services to support Care Delivery Groups as appropriate
- Support general practice to provide an early intervention and proactive approach to the management of people with LTCs (including the frail elderly)
- Increase operational delivery to 7 days a week
- Utilize assistive and information Technology

Our vision is shaped by, and continues to be shaped by our citizens and our staff. As an integrated programme of work our 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
- 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) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

The long term aim of Nottingham City CCG and Nottingham City Council is that through integrated strategies citizens will see a transformed health and social care system. This will be achieved by:

- removing false divides between physical, psychological and social needs
- focussing on the whole person not the condition
- supporting citizens to thrive, creating independence not dependence;
- being tailored to overall need - hospital will be a place of choice, not a default; and
- not incurring delays, people will be in the best place to meet their needs

These aims will be delivered by the following objectives:-

- Develop community health services with social care support linked to groups of GP practices working in geographically proximate areas
- The right care delivered at the right time through Primary care, community services and social care working together in localities; accessing secondary care appropriately.
- Coordinated care through services being delivered by multi-disciplinary teams holding regular MDT meetings.
- Ensure that there is a single person responsible for coordinating the care of citizens with complex needs
- Early identification and intervention of on-going health and social care needs building on risk stratification, risk registers and data held by relevant agencies
- A proactive approach to identify citizens at risk of needing an increased level of care to ensure appropriate support is in place before a crisis situation occurs.
- Restructure and skill up our workforce so that health and social care services work better together to deliver the right care at the right time
- Personalised care planning with access to appropriate specialist support in the community.
- Support to ensure that citizens are empowered to manage their own condition/s
- Support citizens maintain their independence and manage their own care through the creation of effective networks with community, housing and health support services

- Improved transition of care between hospital and community setting.

A performance dashboard will be created and monitored via the Health and Wellbeing Commissioning Executive Group (HWBCEG). The HWBCEG will monitor the following indicators

- Non-elective admissions aged 65+ per 1,000 pop 65+
- Non-elective bed days aged 65+ per head of 1,000 pop 65+
- Non-elective re-admission rate within 30 days
- Non-elective re-admission rate within 90 days
- Excess winter deaths for over 65s
- No of delayed transfer of care days aged 18+ per 100,000 pop
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation
- Proportion of people aged 65+ discharged direct to residential care
- Outcome of short-term support to maximise independence for new and existing clients (STS002a/b)
- Permanent admissions to residential / nursing care aged 65+ per 100,000 pop 65+
- Count of clients receiving long-term services (LTS001a)

The following health gains will be seen across the City:-

- Citizens will report that their quality of life has improved as a result of integrated health and social care services
- Reduction of re-admissions <90 days
- Reduction in Length of Stay for General Medical conditions (Frail elderly, LTC)
- Reduction in avoidable emergency admissions
- Increase of earlier diagnosis of dementia
- An increase of older citizens remaining independent after hospital admission
- An increase in citizens who are satisfied with their care and support

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

This plan fits with the wider approach to improving health and wellbeing in the city and is a key enabler of the Nottingham Plan (Local Authority strategy for wellbeing) and the Clinical Commissioning Groups 3 year commissioning strategy. The key objective of the Better Care Fund proposal is to improve citizens' experience of care through the delivery of more integrated primary, secondary health and social care services.

Integrating care presents significant transitional and operational challenges. In order to realise our overarching benefit of an Integrated Nottinghamshire, there will be a number

of key success factors:

Strong and Deliberative Engagement - Engagement with all our stakeholders is key to making sure that there is a strong sense of ownership of the change. We will have dedicated groups in place to facilitate this, including our Citizens' Panels and engagement workstreams. We will commission an independent communications team that will work with all parties to ensure engagement and communication is carried out effectively for all stakeholders.

Clinical and Organisational Leadership - Leadership is the single biggest contributory factor to the success or failure of a complex change programme. We will ensure our clinicians and leaders are involved. This programme of change will be led by the Health and Wellbeing Board to ensure the integrity of the programme and drive benefits for citizens.

Programme Management - We understand the necessity of rigorous programme management and will ensure this is identified via the ITF plans so we can assure ourselves on the delivery of our plans, management and escalation of our risks and evaluation of our outcomes.

An Integrated Delivery Team - Our delivery teams will include representation from major stakeholder groups, programme management, design, clinical leadership, information, estates and workforce transformation.

Innovative Finance and Contracting - We are considering how to use contracting mechanisms to promote provider collaboration to ensure optimum outcomes for citizens that are also good value for money. We aim to explore new commissioning models such as Capitated and Outcome-Based Incentivised Contracts (COBIC).

Timely access to Data and Systems - All of the interventions proposed require technology enablement. Our organisations are committed to working on sharing data and providing single records for health and social care through Connected Nottinghamshire.

Workforce and Culture - We are committed to delivering a workforce that meets the needs of patients through innovation, inclusiveness and engagement. Strategic direction is provided by the East Midlands Local Education and Training Board (LETB) and Training Council (LETC). Our culture is also one that is hungry for change. Our staff and our citizens see the value of what we are doing and are proud to be a part of such an important transformation.

The delivery of this project will be carried out in the following 3 phases:

Phase One:-
By end January 2014

Workforce

- The following teams will be reconfigured to support the eight Care Delivery Groups:
 - Community Matrons
 - Community Nursing and rehabilitation including support staff
 - Social care assessment (named link)

- The **care coordinator role** will be established an operational from 8am – 8pm, Monday – Friday.
- Champion roles will be established to support teams implementing new ways of working.
- Workforce engagement plan will be in place

Contractual requirements

- Service specification for the care coordinator service will be agreed.
- Service specification for neighbourhood teams will be agreed.
- Agreement re: approach to the ‘alignment’ of the services supporting the independence pathway model.

Operational processes

Minimum requirements for Operational processes will be in place for the following:

- MDT team meetings (NB this is supported through the risk stratification DES)
- Access to services in scope of the programme including the care coordinator
- Secondary care interface ‘choose to admit’ and ‘transfer to assess’

Access and navigation

- Proposal to simplify access to services and navigation around the health and social care system will be agreed and a detailed implantation plan in place.

IT and estates

- Information sharing agreements across health and social care will be in place.
- Relevant health and social care staff will have access to SystemOne and Care First.
- 8 bases for care delivery coordinators will be confirmed.

Secondary Care interface

- Services will be redesigned to support ‘choose to admit’ and ‘transfer to assess’.

By April 2014

Workforce

- The following services will be aligned to support the independence pathway model:

Reablement pathway	Urgent Response Pathway
Intermediate care at home mainstream (CityCare)	Crisis Response service (CityCare)
Intermediate care at home mental health (CityCare)	Nottingham Emergency Homecare Service NEHCS (NCC)
Intake service (NCC)	Through The Night service (NCC)

Contractual requirements

- Assistive technology: A new telehealth service will have been procured and be operational. Telecare expansion to targeted groups will be in place.
- Service specifications to support independence pathway will be agreed.
- The joint venture will be explored as a mechanism to support the independence

pathway model.

- Agreement re: FAQs eligibility and independence pathway processes.

Operational processes

Minimum requirements for Operational processes will be in place for the following with local implementation developed in the CDGs:

- Case management
- Key worker role
- Agreement re: criteria for reablement and community beds to support signposting to appropriate pathway.
- Implementation of the self care pathway to support early intervention.
- Agreement re: how social care assessment process will support the independence pathways.
- Plans for the implementation of comprehensive geriatric assessment will be developed.

Access and navigation

- Nottingham Health and care Point will be integrated to support access to integrated services.

IT and estates

- Shared platform for information sharing to be implemented by 'Connecting Nottinghamshire'

Secondary Care interface

- All referrals from the hospital care coordination team will be transferring patients with a description of care needs, appropriate support will be sourced by the community care coordinators.

Phase Two:-

From April 2014

Workforce

- CDG teams will be supported with additional staff to up skill in Long Term Condition management
- Review of specialist services and integration into neighbourhood teams as appropriate
- Review of social care assessment in pathways including the development of trusted assessors.
- Development of shared roles / holistic worker.
- Reconfigure independence pathway teams to support CDGs as appropriate.

Contractual requirements

- Implementation of joint venture to support independence pathway if agreed.

Operational processes

- Formalise processes to support links to housing and the community and voluntary sector, including workforce opportunities.
- The integrated AT service will be established.
- Support for primary care to work in natural communities.

Access and navigation

- Further development to ensure coordinated support with services out of scope of the programme, for example mental health services.

IT and Estates

- Services supporting CDGs will be collocated where possible.

Phase Three:-

- Continued transfer of specialist support as appropriate into CDGs.
- Continued roll out of IT to support integrated care.
- Continued development of holistic worker role
- Continued development of primary care role in CDGs
- Explore the roll out of integration to other service areas, e.g. mental health services.

Complexity - The model incorporates different levels of complexity to ensure a targeted approach and an appropriate response as citizens move between levels requiring different types of support.

- Complex needs requiring an intensive case management approach, citizens at high risk of unplanned hospital admission.
- Complex LTC and/or care needs deterioration can be managed by a low intensity case management/ monitoring approach, moderate risk of hospital admission.
- Complex LTC (1 or multiple), require enhance support from GP as well as supported self-care.

Secondary Care interface • All referrals from the hospital care coordination team will be transferring patients with a description of care needs; appropriate support will be sourced by the community care coordinators.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The biggest risk to the savings not being realised, is a failure of the integrated care programme to achieve a sufficient magnitude of reduction in demand for acute care. If the required demand reductions are not achieved, then one of 3 situations is likely to occur

- Acute services will not be able to be reduced; There will consequently be a financial shortfall where these were anticipated to be delivering the NHS savings
- Acute services that had already been reduced to achieve the required savings will require putting back in at short notice to deal with the unplanned level of demand. History suggests that having to rapidly put in additional/temporary services is more

costly and provides lower quality than if they were planned.

- Acute services that had already been reduced are unable to be increased to cope with the unplanned demand (either due to inability to recruit necessary staff, or lack of funding in the system to fund the increase in services), resulting in impacts on quality and experience to patients, increased risk of harm, non-achievement of access targets/service standards, and a significant risk to organisational reputations.

The integrated programme aims to mitigate the risks of additional activity in the acute setting by:-

- Enabling, promoting and developing care into the community. This will involve increasing capacity in provision and workforce and working with the local authority to identify gaps and analysis in current provision.
- Prevent additional acute activity by targeting and managing conditions prior to escalation in a holistic way, thus reducing avoidable admissions and ED attendances.
- The plans will be underpinned by data obtained from the Utilisation Review of un-scheduled medical in-patient admissions at NUH, in-patient admissions to Lings Bar Hospital and the Intermediate Care Utilisation Review of bed based and home based services. The 2010 review identified the following reason for admission reviews not meeting the criteria for admission were:
 - (one third) External factors e.g. availability of Nursing Home Care, community provision, assessment
 - (Two-thirds) Internal Trust factors e.g. waits for clinical assessment.
- Appropriately 28.4% did not have a continued need for an acute stay. In most cases, the failure to pass admitted patients from acute to a more appropriate level of care was due to external processes such as capacity constraints in existing services or incomplete discharge planning. Those patients who did not meet the continued stay criteria could have been managed at a lower level of acute care or Home Care or at home with a returning out patient appointment.

Further analysis through the SIGNS group in 2013 concluded that 2,596 patients could have been discharged earlier freeing up 14,090 bed days, over one year. These patients required a range of services in the community including therapy and assessment, 24 hour intensive nursing/therapy assessment, complex sub acute nursing and therapy, nursing and therapy needs which could be managed in the home or low level Reablement services.

The integrated Programme work will see an impact in the acute sector from November 2014

e) Governance

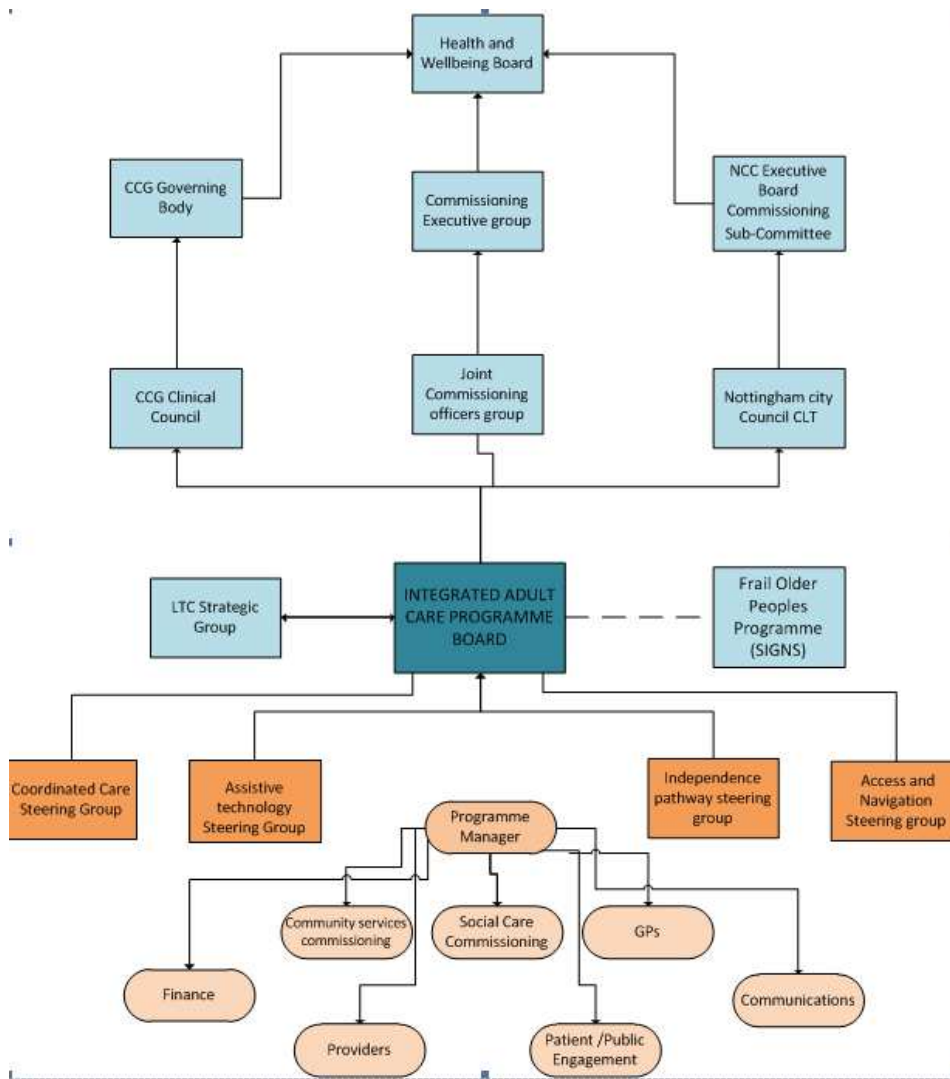
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

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

Appendix 1

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. An Annual Report will be presented to the Health and Wellbeing Board and subsequent Governing bodies each year. (please see governance map below).

The operational management of the Integrated Transfer Funds will be the responsibility of the ITF programme Manager. This will be incorporated within the ITF plan, and will be a shared position between health and the local authority.



NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

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, building community capacity

Please explain how local social care services will be protected within your plans

Schemes identified in the plan support the model of integrated care currently being implemented and will therefore support delivery of objectives.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

Nottingham City sees 7 day working as a critical component for its planning assumptions to support hospital discharge and avoid admissions to both hospital and care homes.

A crisis coordination team has already been commissioned to support discharge over 7 days with a number of seven day services already in place, such as Rapid Response Teams and Intermediate Care Teams, new services are outlined in the BCF plan that will require further development to ensure that services are in place to meet the identified needs of patients through established working groups while working within the strategic direction of the Adult Integrated agenda.

All relevant providers have been informed of plans to further expand 7 day working

through the 2014/15 contract negotiations.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

The core commissioning Stakeholders can confirm that they are not using the NHS Number as the primary identifier across all health and care services

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

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.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

The stakeholders are committed to sourcing systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Nottingham City is a member of the newly formed Record Sharing Group. This group comprising of clinical, and governance/ Caldicott 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.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to

Appendix 1

risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Multi-disciplinary teams comprising of both health and social care staff will be working with primary care to identify patients at high risk using the Devon risk stratification tool. 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 and will be implemented in April 2014.

3) RISKS

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

Risk	Risk rating	Mitigating Actions
Acute provider already has significant Cost reduction targets which could impact on quality and delivery if not managed prior to money being removed.	High	Ensure a proposal is discussed around phased activity and finance, to ensure core services are not significantly affected
Increase in ED and admissions capacity	High	Ongoing monitoring of activity with close links to community provision to scale up and down as required
Insufficient skilled resources to manage increased complexity within the community	High	Collaboration with community providers to ensure training and development programmes are in place to manage influx and increase of skills needed.
Implementation of NHS Number	High	Working collaboratively with productive IT to develop Data sharing protocols and systems requirements
Existing contract not fit for purpose to meet shared responsibility	High	Work with stakeholders to understand implications and scope opportunity of developing shared responsibility.
Impact on workforce in regards to remit, responsibility and job description	Medium	Work with HR to ensure staff are engaged with during the process and undertake a training needs analysis.
Insufficient internal resource to streamline discharge of care from acute to community	Medium	Work with NUH to monitor performance of discharge to transfer to assess workgroups.
Confusing access and navigation points	Medium	Collate and migrate existing access points to streamline and remove fragmentation.
Sign up and cultural changes required to enable whole scale change from all partners, including changes to ways of working is not achieved within the timescale	High	On-going leadership from the Integrated Programme Board Early engagement of partners with work programmes agreed in partnership at a senior level

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		Planned change management approach for all organisations involved to engage and communicate these changes to the front line
There is a risk that as performance related funding is reliant on outcomes these may not be evidenced in the short to medium term	High	<p>On-going monitoring of outcomes at a senior level through the Integrated Programme Board and Commissioning Executive Group with a robust approach to performance management</p> <p>On-going monitoring and evaluation of programmes to ensure that services/projects within the programmes are fit for purpose and meeting expected outcomes within timescales</p> <p>Services to be procured on an outcomes basis with funding linked to outcomes therefore a shared risk between commissioners and providers</p>
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	High	Maintain and sustain strong links and communication channels with Area Team, NHS England
There is a risk that implementation of the changes will impact on the financial stability of providers	High	<p>On-going leadership from the Integrated Programme Board</p> <p>Early engagement of partners with work programmes agreed in partnership at a senior level through Commissioning Executive group</p> <p>Ensure individual projects and overall programme subject to robust analysis and modelling to ensure any financial impact on providers is clear</p>
There is a risk that staff moving from existing services to care delivery groups will destabilise existing services leading to overall loss of performance	High	<p>Reduce scale of services and / or phase delivery to accommodate extended recruitment timescales</p> <p>Use of agency staff to bridge gaps</p>

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		Early discussions with regional workforce development teams to facilitate long term recruitment and development planning
Access to Risk profiling Data. Legalities around access.	High	Work collaboratively with information governance team to identify impact, risk and outcomes in a bid to produce a legally appropriate response.
Monitoring data for Delayed transfer of care may not be as accurate as required due to process of 'calling off' section 5 requests to local authority.	High	Working with NUH and LA to ensure accurate process is in place in regards to use of Section 2 and 5.
There is a risk that there is public resistance to the proposed changes and that population behaviour change will not materialise	Medium	Plan to be supported by the on-going development and implementation of a communication and engagement strategy
There is a risk that implementation of the changes will result in an increase in admissions to care homes	Medium	On-going leadership from the Commissioning Executive Group to monitor Bed availability in care home Intermediate Care / Assessment Beds to be used flexibly when necessary
There is a risk that social care funding challenges result in a reduction of available care packages to support long term care resulting in a shift in cost of long term care to	High	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
There is a risk that implementation of the changes will impact on the financial stability of providers		Early engagement of partners Via Integrated Programme Board. Ensure individual projects and overall programme subject to robust analysis and modelling to ensure any financial
There is a risk that as performance related funding is reliant on outcomes these may	High	On-going monitoring of outcomes at a senior level through the CEG with a robust approach to

Appendix 1

<p>not be evidenced in the short to medium term</p>		<p>performance management On-going monitoring and evaluation of programmes to ensure that services/projects within the programmes are fit for purpose and meeting expected outcomes within timescales Services to be procured on an outcomes basis with funding linked to outcomes therefore a shared risk between commissioners and providers</p>
<p>There is a risk that if the existing contractual arrangements with Nottingham University Hospitals NHS Trust remain unchanged this will have a negative impact on delivery of the plan</p>	<p>High</p>	<p>Early engagement of partners with work programmes agreed in partnership at a senior level</p>
<p>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</p>	<p>Medium</p>	<p>Early engagement of partners with work programmes agreed in partnership at a senior level Planned change management approach for all organisations involved to communicate these changes to the front line</p>



Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

The following outcomes and benefits will be seen across the City :-

- Citizens will report that their quality of life has improved as a result of integrated health and social care services
- Reduction of re-admissions <90 days, citizen stating that they feel more supported in the community
- Reduction in Length of Stay for General Medical conditions (Frail elderly, LTC), patients are seen in the most appropriate location.
- Reduction in avoidable emergency admissions
- Increase of earlier diagnosis of dementia to ensure patients receive timely treatment
- An increase of older citizens remaining independent after hospital admission
- An increase in citizens who are satisfied with their care and support

The following performance measures will be put in place and monitored via the Health and Wellbeing Commissioning Executive Group:-

- Non-elective admissions aged 65+ per 1,000 pop 65+
- Non-elective bed days aged 65+ per head of 1,000 pop 65+
- Non-elective re-admission rate within 30 days
- Non-elective re-admission rate within 90 days
- Excess winter deaths for over 65s
- No of delayed transfer of care days aged 18+ per 100,000 pop
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation
- Proportion of people aged 65+ discharged direct to residential care
- Outcome of short-term support to maximise independence for new and existing clients (STS002a/b)
- Permanent admissions to residential / nursing care aged 65+ per 100,000 pop 65+
- Count of clients receiving long-term services (LTS001a)

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

--

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

A performance dashboard will be created and monitored via the Health and Wellbeing Commissioning Executive Group (HWBCEG). A joint programme Manager post will have the responsibility for ensuring the necessary performance and outcomes are delivering against the agreed metrics, with the HWBCEG providing oversight and guidance, feeding into the Health and Wellbeing Board through quarterly reports.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

--

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Metric Value		N/A	
	Numerator			
	Denominator			
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Metric Value		N/A	
	Numerator			
	Denominator			
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	Metric Value	10.2	9.9	9.5
	Numerator	27	24	24
	Denominator	245725	245,725	245,725
		Apr 12-Sept 13	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	Metric Value	3.34	3.13	3.00
	Numerator	603	561	521
	Denominator	300,336	306,725	306,725
		Apr 12-Aug 13	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience (for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used)		(insert time period)	N/A	(insert time period)
Health related quality of life for people with long-term conditions. Weighted EQ-5DTM scores for all responses from people identified as having a long-term condition.	Metric Value	69.8	71.5	73.3
	Numerator			
	Denominator			
		(April 2012 - March 2013)	(April - September 2014)	(October 2014 - March 2015)

Draft Plan

Better Care Fund

Maria Principe

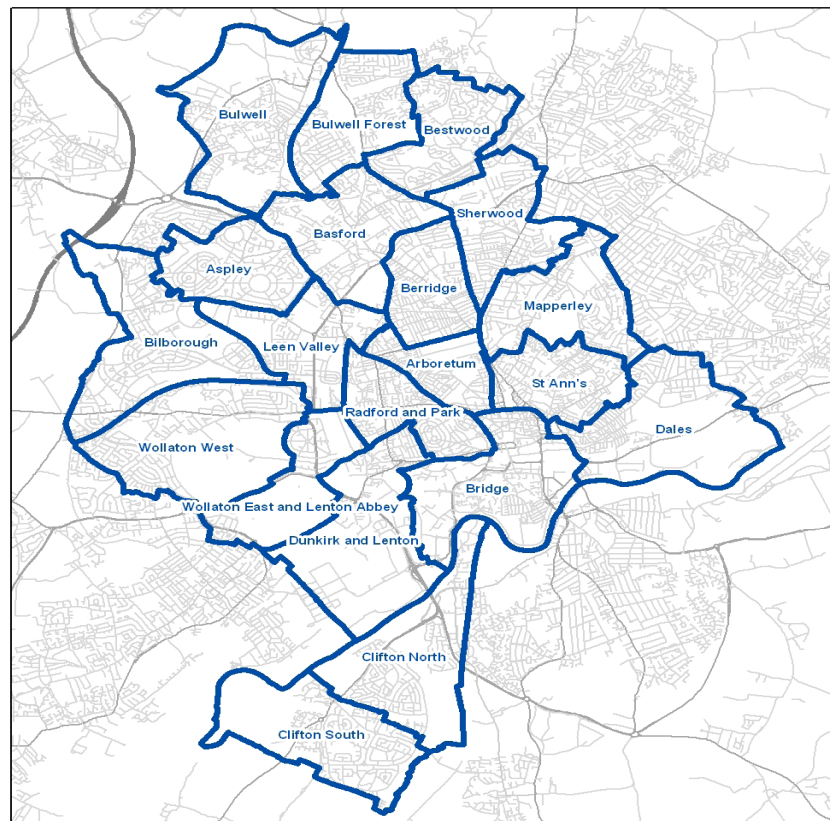
**Director Primary Care and Service Integration, NHS Nottingham
City Clinical Commissioning Group**

Candida Brudenell

Director Childrens and Adult Service Nottingham City Council

Coverage

This plan covers the boundaries of Nottingham City



Title: Nottingham City Wards

Key  Wards

Map produced on:
11/04/08
Map produced by:
Policy and
Information Team



City of

NOTTINGHAM

Environment and Regeneration

0 0.5 1 2 Km

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Nottingham City

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National Conditions

- Protection for social care services (not spending)
- 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing between health and social care, based on the NHS number
- Joint approach to assessments and care planning and accountable professional
- Agreement on the consequential impact of changes in the acute sector



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Nottingham BCF

- NOT new funding
- Additive funding element equates to 5%
- BCF Focus delivering:
 - Integrated Adult Care Programme
 - Chose to Admit
 - Transfer to Assess

Better Care Fund Elements

Schemes:	Investments
Independence Pathway	10,060,093
Coordinated Care	8,118,690
Assistive Technology	1,145,000
Access & Navigation	1,815,852
Management	160,000
Carers	1,041,857
Disabled Facilities Grant	1,863,000
TOTAL INVESTMENT	24,204,492



Citizen Feedback

- The health and social care system is complex; it is difficult to access appropriate support in a timely way.
- Stakeholder engagement events demonstrated a strong shared ambition for the future which includes the following characteristics
 - Simplifying the system
 - Taking an holistic approach
 - Citizen centred / seamless
 - Shared information
 - Services integrated across health and social care
 - Single point of access
 - Joint outcomes

Joint Vision

“We will improve the experience of and access to health and social care services for citizens. More citizens will report that their quality of life has improved as a result of integrated health and care services. The number of citizens remaining independent after hospital admission will increase with improved and seamless transfers of care”



For Ada's sake its time for us to
work together better.

NHS

Nottingham City

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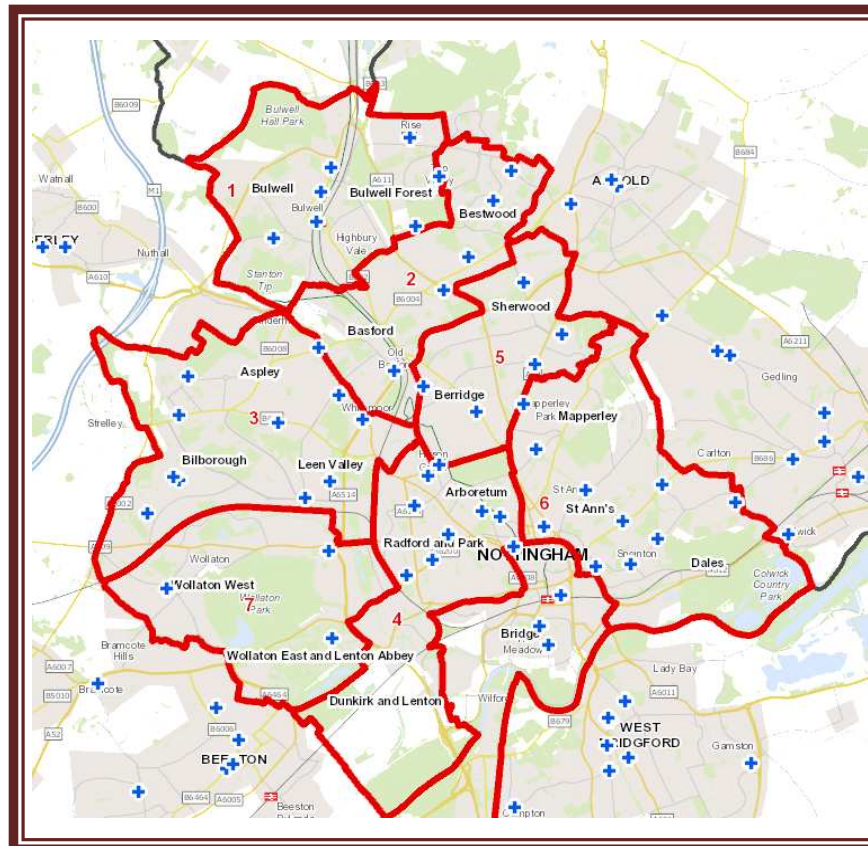
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Aim

- Remove false divides between physical, psychological and social needs
- Focus on the whole person not the condition
- Support citizens to thrive, creating independence not dependence;
- Services tailored to need - hospital will be a place of choice, not a default; and
- Not incur delays, people will be in the best place to meet their needs

Characteristics of Model

- Single Point of Access
- NHS Number as core patient identifiable link
- Implementation of Care Coordinators
- Shared community workforce
- Integration with LA
- Tailored services based on population need with equitable access across all Care Delivery Groups CDGs
- MDT management of patient care
- Access to assistive technology



Objective

- Develop community health services with social care support linked to groups of GP practices working in geographically proximate areas
- Coordinate care through services being delivered by multi-disciplinary teams holding regular MDT meetings.
- Ensure that there is a single person responsible for coordinating the care of citizens with complex needs with access to appropriate specialist support in the community
- Early identification and intervention of on-going health and social care needs building on risk stratification, risk registers and data held by relevant agencies
- Restructure and skill up our workforce so that health and social care services work better together to deliver the right care at the right time
- Support to ensure that citizens are empowered to manage their own condition/s through the creation of effective networks with community, housing and health support services
- Improved transition of care between hospital and community setting.



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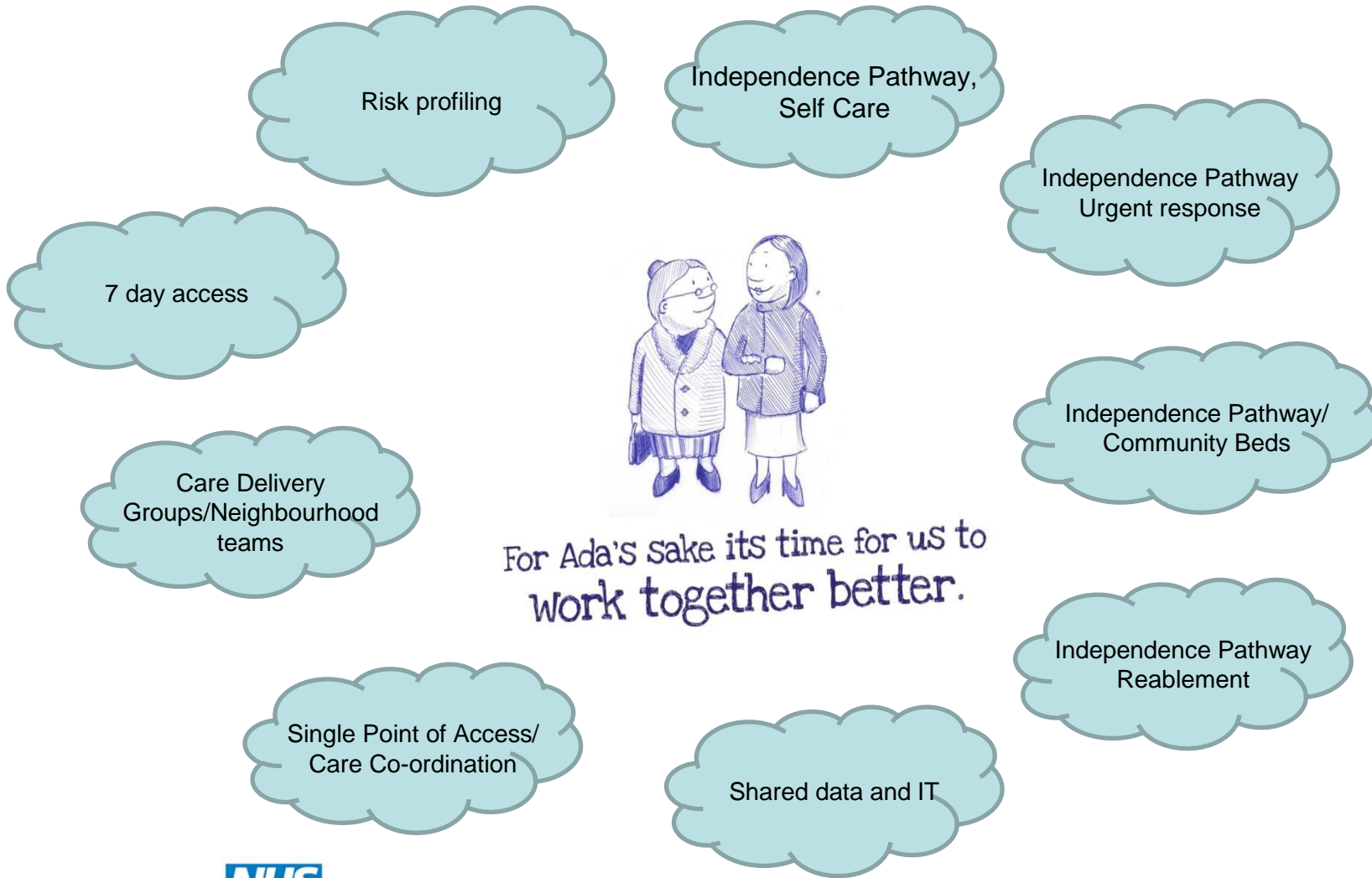


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What programmes will deliver this?



What programmes will deliver this?



Nottingham BCF Additive Elements

- Care Coordination Service
- Expansion Health & Care Point
- Tele-health Programme
- MH In reach Discharge Coordinators
- 7 Day Working
- => 18% of total Fund

What will these Programmes deliver?

- Citizens will report that their quality of life has improved as a result of integrated health and social care services
- The health community will see a reduction of re-admissions <90 days
- The acute sector will see a reduction in Length of Stay for General Medical conditions (Frail elderly, LTC)
- The health community will see a reduction in avoidable emergency admissions
- The community will benefit through earlier diagnosis of dementia
- Increased number of patients will remaining independent after hospital admission



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What will this mean for Ada?

Right care delivered at the right time in the right place

24/7 Care delivered through MDT,

Workforce skilled to manage her condition at home

One point of contact to coordinate her care



Personalised care planning with access to specialist services

Earlier identification and intervention

For Ada's sake its time for us to work together better.

Support to enable her to manage her own condition

Seamless transition of care between providers

Support to enable her to maintain her independence



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Appendix 3 Equality Impact Assessment Form

Name and brief description of proposal / policy / service being assessed

Better Care Fund

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

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

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

Up to 25% of the BCF budget will be performance related and released on attainment of aspirational targets against the following metrics:

- Residential and Nursing Care Admissions
- Delayed Transfers of Care
- Emergency Hospital Admissions
- More Effective Reablement Services
- Patient & Service User Experience
- Local Measure (to be determined)

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

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

Information used to analyse the effects on equality

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

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

Appendix 3 Equality Impact Assessment Form

	Could particularly benefit (X)	May adversely impact (X)	How different groups could be affected: Summary of impacts	Details of actions to reduce negative or increase positive impact (or why action not possible)
People from different ethnic groups			<p>The objective of the Integrated Adult Care programme is to streamline and integrate Health and Social Care service delivery models and systems, positively transforming citizen experience of how their needs are met. The development of an integrated care pathway will be of benefit to all those with long-term conditions (including older people with complex needs) will be based on, and responsive to, the aspirations of the citizen and predicated on early intervention, prevention, maximising independence and optimising citizen choice and control.</p> <p>Citizens contacting Health and Care Point will benefit from an integrated and expanded service. This will mean that they are more likely to be routed to the appropriate function to meet their needs (enablement, reablement, crisis) and in a shorter timeframe.</p> <p>The care coordination service will result in a more streamlined service for the frail elderly and those with long-term conditions. The aim of a care coordinator is to complete administration tasks to release clinicians to focus on direct patient contact and support. The role of the care coordinator will be to:-</p> <ul style="list-style-type: none"> • Navigate and coordinate services to meet individual's needs across the CDG. • Act as a point of contact for professionals, citizens and carers. • Monitor service capacity to assist the CDG to manage demand. • Complete relevant referral documentation and chase referrals as required. • Gather information to support assessment and intervention. • Order and follow up equipment orders. <p>All citizens will benefit from 7 day access to primary care services. BCF funding is concerned with ensuring that there are routes into community health and social care provision and assessment over the weekend. This will in turn facilitate discharge from hospital.</p>	<p>Performance against BCF performance objectives will be monitored across Health and Social Care and reported to the Health & Well-being Board on a bi-annual basis and to the Health & Well-being Board Commissioning Executive Group on a quarterly basis. A particular focus of this will be the value of the additive elements in meeting overall BCF and Integrated Adult Care objectives</p> <p>An evaluation framework has been commissioned as part of the Integrated Adult Care programme. A key focus of evaluation will be qualitative data from citizens and health and social care professionals as to the ongoing benefits accrued as a result of the programme. Regular evaluation reports will be provided to the Integrated Adult Care Programme Board and modifications will be made to the programme as appropriate.</p>
Men, women (including maternity/pregnancy impact), transgender people				
Disabled people or carers	x			
People from different faith groups				
Lesbian, gay or bisexual people				
Older or younger people	x			
Other – please specify				

Appendix 3 Equality Impact Assessment Form

			<p>People with a long-term condition will benefit from the roll-out of Telehealth. By 2018 200 patients will be able to have their vital signs monitored remotely in a home rather than hospital environment. This will facilitate prevention and enable nurses to focus resources on those with critical care needs</p> <p>The expansion of the Mental Health In-reach Discharge service will benefit those with acute mental health needs by reducing the amount of time taken to facilitate discharge from a hospital to community setting</p>	
<p>Outcome(s) of equality impact assessment: No major change needed <input checked="" type="checkbox"/> Adjust the policy/proposal <input type="checkbox"/> Adverse impact but continue <input type="checkbox"/> Stop and remove the policy/proposal <input type="checkbox"/></p>				
<p>Arrangements for future monitoring of equality impact of this proposal / policy / service: Health and Well-being Board Commissioning Executive Group – quarterly monitoring reports</p>				
<p>Approved by (manager signature): Antony Dixon – Strategic Commissioning Manager</p>			<p>Date sent to equality team for publishing: Send document or link to equalityanddiversityteam@nottinghamcity.gov.uk</p>	