Updated March 2016

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Part 2 is in Excel and contains metrics and finance.

Contents

1 Plan Details

A Summary of Plan

Local Authority	**Nottingham City Council**
Clinical Commissioning Groups	**NHS Nottingham City CCG**
Boundary Differences	**Boundary is coterminous with the City Council.**
Date agreed at by CCG & LA:	**21st March 2016**
Date submitted:	**21st March 2016**
Minimum required value of BCF pooled budget: 2016/17	**£ £21,504,692** (ccg minimum)
Total agreed value of pooled budget: 2016/17	**£ £25,857,401**

B Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	[April submission version to be signed]
By	Dawn Smith
Position	Chief Officer, NHS Nottingham City CCG
Date	[April submission version to be signed]

Signed on behalf of Nottingham City Council	[April submission version to be signed]
By	Alison Michalska
Position	Corporate Director of Children and Adult Services, Nottingham City Council
Date	[April submission version to be signed]

Signed on behalf of the Health and Wellbeing Board	[April submission version to be signed]
By	Councillor Alex Norris
Position	Chair - Nottingham City Health & Wellbeing Board
Date	[April submission version to be signed]

C Related documentation

Document or information title
01 Nottingham City Health and Wellbeing Strategy 2013-16
02 Nottingham City BCF Narrative plan 2015-16
03 Updated case for change 2016-17
04 CDG Health Profiles
05 Connecting Care Newsletter Issue 19 – February 2016
06 Annex 1 detailed scheme description forms 2016-17
07 Nottingham BCF Audit Report 2014/15
08 Nottingham BCF & Integrated Care Risk Log
09 Summary from joint HWB workshop on workforce issues
10 Nottingham City Joint Carers Strategy 2012-17
11 Wellness in Mind – Nottingham City Mental Health and Wellbeing Strategy 2014-17
12 Sharing the future model for citizen engagement
13 Impact change model (Self-assessment against DTOC actions)

2 The Local Vision for health and social care services

Nottingham City CCG and Nottingham City Council share a vision to enable our citizens to live longer, be healthier and have a better quality of life, especially in communities with the poorest health. We have achieved much together in recent years, particularly in implementing our integrated care programme and progressing the Better Care Fund. There is though recognition that only so much can be achieved without further breaking down organisational boundaries, eradicating the corporate silos and forging a new approach to commissioning and provision.

Our approach to integrated care for adults with long-term conditions and the frail elderly will be extended to cover the entire adult population. Importantly, we need citizens to continue to receive more care in their home or community, reducing unnecessary hospital admissions and shortening hospital stays. Our commissioning needs to be joined up and strategic, focusing on the value achieved or outcomes gained rather than on activity. Wherever services are provided, they must be high quality, accessible, sustainable and based on population need.

We need health and social care organisations to be working together in a 'place-based system of care' that will best improve the health and wellbeing of local people. This will see organisations acting collectively for the best interests of communities, managing the common resources available to them. The alternative to this might be for each organisation to adopt a 'fortress mentality', acting to secure its own future regardless of the impact on others.

In line with the five year forward view and building on the implementation of our model of integrated care our vision for Nottingham City is:

"To achieve the best possible health and wellbeing in our communities, breaking down current organisational barriers, so that citizens are encouraged to look after themselves wherever possible, with excellent integrated health, social care and other public services supporting them when they need them"

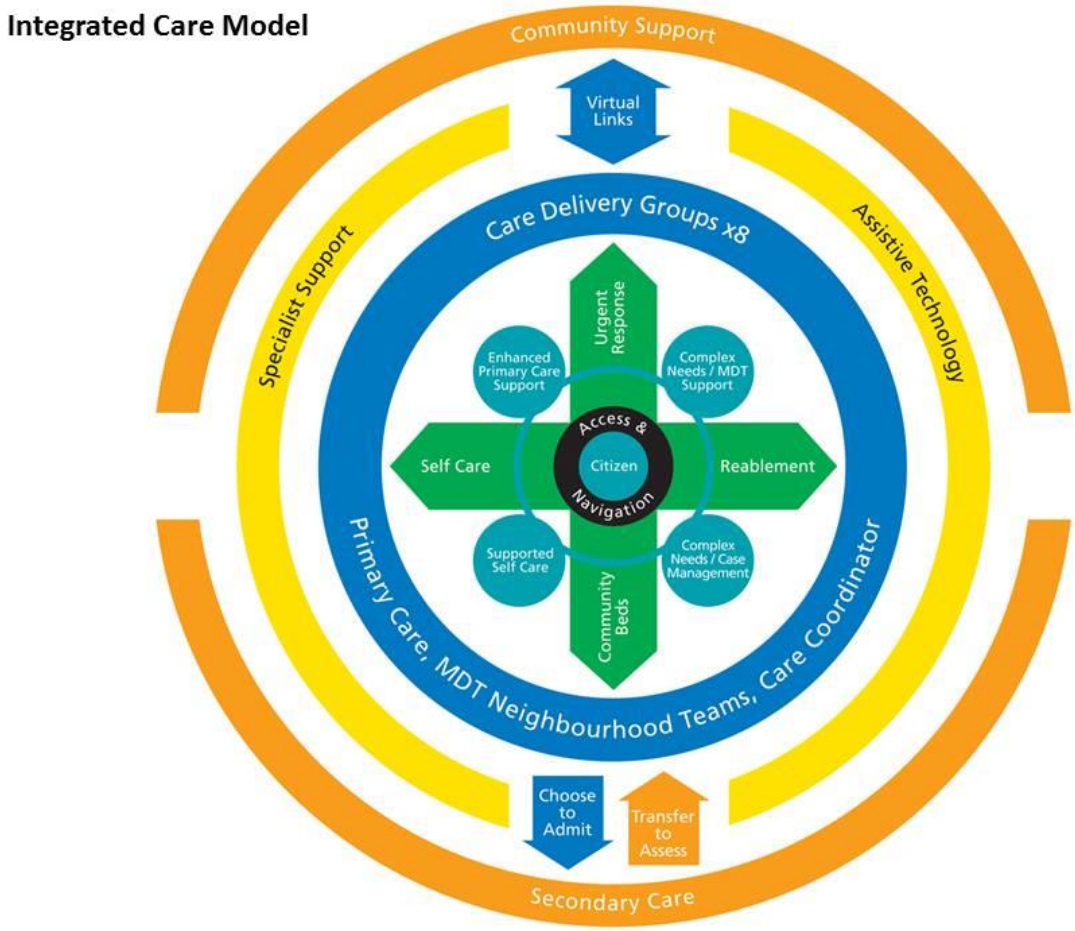
Key features of our vision and strategy will be to:

- Create a more cost efficient and clinically effective approach to care
- Ensure care is delivered in the right place – by the right people – with the appropriate skill mix
- Ensure care is delivered at home or in the community wherever possible
- Ensure provision of high quality, clinically safe and accessible services
- Focus on prevention and the ways in which individuals and resilient communities can best support themselves
- Move away from a 'paternalistic' top-down approach to one in which individuals are better informed, empowered and managing their own conditions
- Ensure that decisions are made in the best interests of citizens – not organisations
- Build medium and long term sustainability in response to rising demand and constrained resource
- Continue to work towards reducing and ending health inequalities in our communities

Our BCF plan for 16/17 will continue to support the implementation of the Nottingham City Health and Wellbeing Strategy **(document 01)** and is set within the context of longer term plans for the integration of health and care. Work is underway to support the development of System Transformation Plans (STPs) building on the success of our integrated care programme and work of the HWB.

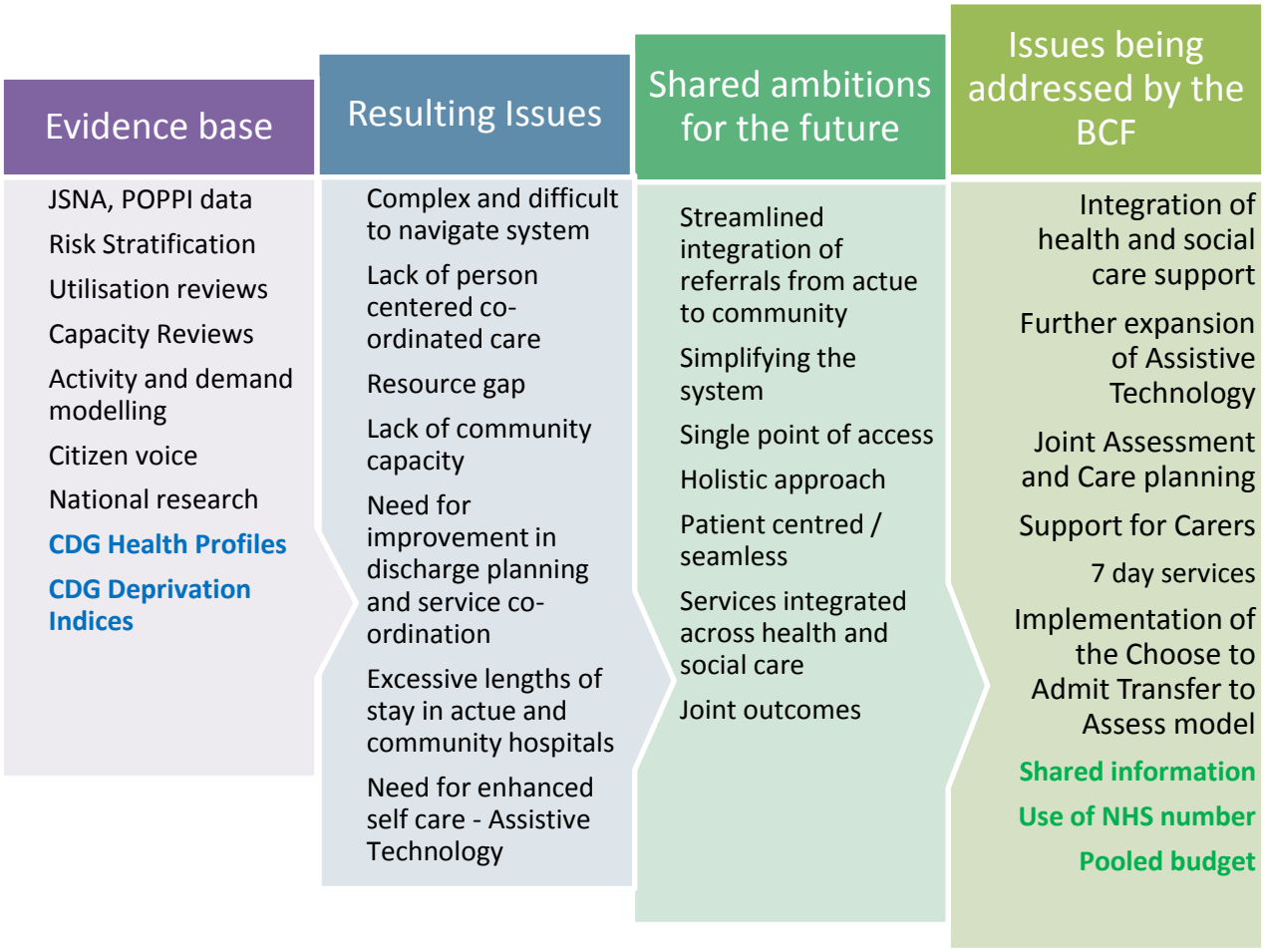
Furthermore it has provided a formal mechanism bringing together health and social care to explore system wide issues and has ensured implementation of the model. We will build on our achievements to date to take integration to the next phase which will include joint prioritisation of resources, avoiding duplication of commissioned services, flexibility across organisational boundaries for spending decisions and targeting of investment to meet shared priorities by taking a whole economy perspective.

We will continue to develop the aspects of the integrated care model already in place, for example the Care Delivery Groups. The BCF will support the next steps of the model's implementation such as self-care and mental health integration.



3 An evidence base supporting the case for change

We have reviewed the case for change described in our 15/16 plan, this remains consistent and we have added in additional information specific to Nottingham which we are using to inform the development of integrated care plans across the system. This is summarised in the diagram below which describes the link between the evidence base, resulting issues, our ambitions for change in Nottingham and how we will meet unmet need through the BCF. Please refer back to the 15/16 BCF narrative plan, **document 02**.



Key: **Green = Progress from 15/16 Blue = New for 16/17**

Additional information is available in **document 03** which has been produced to support the wider plans for transforming care and integration locally; this provides updated figures on long term condition prevalence, life expectancy, cancer survivorship, mental health prevalence and levels of deprivation across each Care Delivery Group in Nottingham.

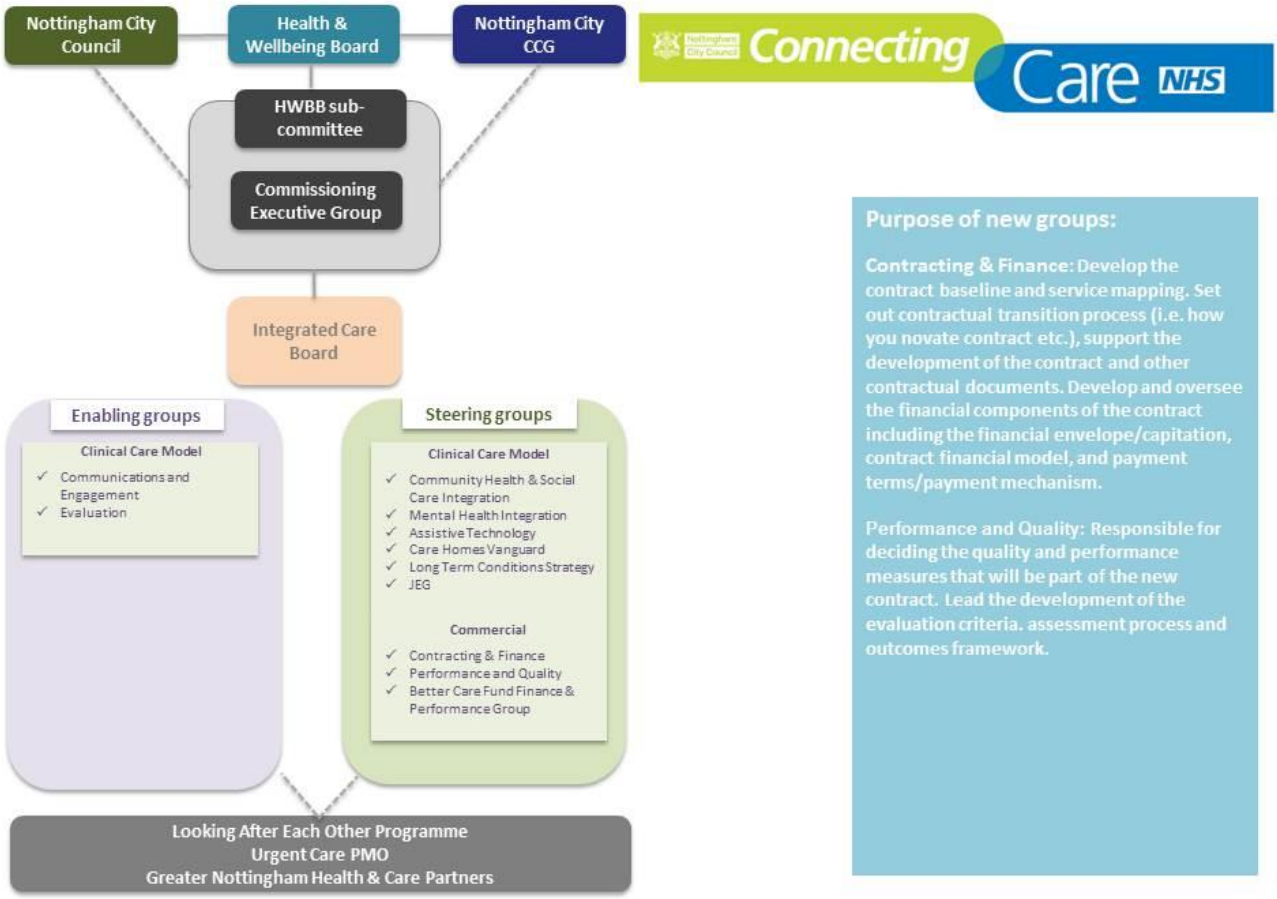
Finally to support the planning and delivery of co-ordinated care on a locality basis Public Health have produced health profiles for each Care Delivery Group, these are available in **document 04**.

Each of the "schemes" within our BCF plan will continue to address the local issues which we have identified and will continue to be implemented through our Integrated Care Model. Full descriptions for each scheme are available in **document 05**.

4 A coordinated and integrated plan of action for delivering change

Governance and accountability arrangements remain in place as outlined in our BCF 2015/16 plan with the HWB being ultimately responsible for maintaining oversight of the health and social care system. The Health and Wellbeing Board Sub-committee was established in April 2015 and has delegated authority to make decisions in relation to the BCF, papers for this committee can be accessed via the following link: http://bit.ly/253L5X8

The BCF and Integrated Care Programme Board continue to oversee development and delivery of the plan, with monitoring undertaken by the BCF Finance and Performance Group. The BCF governance arrangements are outlined in the chart below. As an example of the communications materials produced about the programme for key stakeholders and staff we have included Issue 19 of our Connecting Care newsletter – **document 06**.



Having reviewed schemes as part of the evaluation process, there will be minimal changes to schemes / services within the BCF plan.

BCF scheme	Amendments to 2015/16 plan	Rationale
Access and navigation	Additional funding for integrated health and care point	Supports our aim to simplify access to and navigation through services for citizens
	Information and advice directory	Under section 4 of the Care Act 2014 Nottingham City Council and partners need to ensure that there is robust, accessible information for citizens to help them to understand services available to them.
Assistive Technology	Additional funding for new delivery model	Supports early intervention
Carers	Addition of primary care carers service	Supports the planned redesign of carers services
Coordinated Care	Addition of CPN step down pilot	Support integration of mental health services and increased support for neighbourhood teams
	Addition of CDG social care assessor posts	Supports a change in the model of social care delivery to move to CDGs
	Addition of social care 7 day working	Supports plans for expansion of 7 day support for citizens
	Funding for 7 day working in the Care Homes Nursing Team	Supports plans for expansion of 7 day support for citizens
	Funding for 7 day working for the Care Co-ordinators service	Supports plans for expansion of 7 day support for citizens
Independence pathway	Addition of older people home safety and improvement service	Supports prevention and early intervention
	Additional posts in enablement gateway	Supports early intervention across each Care Delivery Group in the City
Programme costs	Additional 3 posts	Supports delivery of the planned transformation

Health and social care providers and housing colleagues have been involved in the development and agreement of the BCF 2016/17 plan, either through representation on the BCF / Integrated Care Programme Board or through contract negotiations.

Since 2014 we have undertaken two audits of the BCF programme, the first audit review is available in **document 07**.

In December 2014 an audit review was completed in respect of the preparations for the implementation of the Better Care Fund, focusing on the governance arrangements surrounding the management and delivery of the Better Care Fund. The report aimed to ensure that:

- ✓ There is a structured framework in place to coordinate, communicate, manage and control the activities that support implementation of the Better Care Fund.

- ✓ There is clear CCG senior management ownership, leadership and clinical involvement in the Better Care Fund.

- ✓ Regular management information is reported through the governance structure of the CCG which provides appropriate assurances to the Governing Body in relation to the management of the Better Care Fund.

- ✓ Risks in relation to the Better Care Fund are being identified and appropriately managed within the CCG's risk management framework.

The report gave **significant** assurance that the CCG working in partnership with Nottingham City Council was putting in place appropriate governance arrangements in relation to the BCF.

A second audit review is currently underway with the following focus:
Risk Management

- How risks relating to the BCF are identified and recorded
- The process for assessing risk, assigning responsibility and managing mitigation
- Reporting of risk and how BCF risks are integrated with other CCG risk management processes.

Developing Governance Structure

- Review of the effectiveness of the governance structures in the light of BCF operation.

The report is due to be published in April 2016.

A risk register is regularly reviewed at Programme Board, this is available in **document 08**. Risks and issues associated with the work to implement better data sharing between health and social care are recorded and managed through Connected Nottinghamshire programme.

5 BCF National Conditions

NATIONAL CONDITIONS

A Plans to be jointly agreed

Health and social care providers, housing and third sector colleagues have been involved in the development and agreement of the BCF 2016/17 plan, either through representation on the BCF / Integrated Care Programme Board or through contract negotiations. Further details are provided in section F.

We recently held a Chief Officers event to review progress and plan for the next phase of integration. Our strategic priorities were identified as follows and our approach to developing a work plan agreed.

1. Culture and leadership
2. Prevention and early intervention
3. Governance
4. Vehicle for delivery
5. New models of care and guidelines and pathways
6. Finance
7. Communications
8. Citizen engagement
9. Workforce and competencies
10. Information sharing

A joint workshop was hosted by Nottinghamshire and Nottingham City HWBs to explore possible local solutions to known workforce issues. The workshop was designed to give participants the opportunity to share experiences and discuss local strategies to address workforce issues, such as 7 day working, use of agency staff, integrating workforce, skills and retention, new models of care, and implications of the living wage. **Document 09** contains a summary of the findings and outlines the next steps locally.

B Maintain provision of social care services

There has been no change in the eligibility threshold provided. Prior to the Care Act, the threshold set by the City Council was High Moderate and is continuing to provide support at this level which goes beyond the requirements of the Care Act.

The principle mechanism by which this is delivered is through the Enablement Gateway. The Enablement Gateway team provides a combination of low level social work and Occupational Therapy interventions. They make use of low cost/no cost services which already exist and can help to re-engage citizens with their community. The team is funded via the Better Care Fund to provide early intervention and reduce the need for long term care services. Gateway team members provide a holistic assessment which may lead to information around connections to local community organisations, advice and low level/low cost aids and equipment to help people retain their independence at home and signposting citizens to other services in the community which may be able to support them with their independence and care needs.

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 financial 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.

The independence pathway services 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, for further details in relation to demographic change see **document 03**.

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.

The adult social care schemes within the BCF have been largely maintained. There has been some additional strengthening of provision in relation to hospital discharge and to supporting the roll out of 7 day working. Additional funding has also been used to strengthen more effective access through the Health and Social Care Point and to develop a stronger presence for social care in the local Care Delivery Groups.

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

- Community Alarm provision.
- Additional Hospital Discharge assessment posts
- Additional Specific Reablement Assessment Posts
- Additional Specific in-reach discharge posts
- Older person Home Safety and Improvement Service
- Seven Day Services in Rapid Response and Hospital Discharge
- Care Delivery Group Assessor posts
- Access and Navigation Pilot

There has been an increase in the protection of social care services which is integral to the delivery of an effective integrated care model in Nottingham. Within the 15/16 BCF plan the amount protected for social care was £6.807 million; we can confirm that within the 16/17 plan we will protect £7.403 million.

Implementation of the Care Act through the BCF

The 2013 Care Act was introduced by the City Council on 1st April 2014. We recognise that it was designed to:

- Embed the wellbeing principle into discussions between assessment colleagues and citizens
- Shift the focus of service provision towards being preventative and maximising the skills and independence of citizens through taking a skills based approach with person centred planning

This has been achieved in Nottingham by the following changes:

- Advocacy – The contract with the current provider of advocacy was amended to ensure compliance with the Act.
- Providing information and advice – A new service has been commissioned to provider information and advice as per the content of the Act.
- Adult safeguarding – Internal systems and culture change programme was undertaken. Adult Safeguarding Board set up as a statutory Board.
- Provider failure planning – Established local market oversight process and procedures and a robust provider failure action plan
- Eligibility for services, following a national framework – Internal systems, paperwork and training change programme was undertaken.
- Supporting carers and giving them new rights to support services - The contract with the current provider of services for carers was amended to ensure compliance with the Act. Staff training was undertaken to ensure assessment colleagues' compliance. Carers now receive a great deal more direct support.
- Working in partnership with other agencies – Nottingham City has a programme of Health and Social Care Integration which includes BCF monies.
- Citizens moving between local authority areas – New arrangements are embedded around ordinary residency and transfer between local authority areas.
- Social care in prisons – The Council is meeting its requirement to assess the social care needs of prisoners.

Implementation of the Care Act duties aligns with BCF principles and activity to deliver integrated care. All social care services funded via the Better Care Fund could be deemed to be working towards further implementation of the spirit of the Care Act, as detailed above. Examples of this could include, among others:

- The preventative and enabling nature of services such as: Telecare, Care Coordinators, drop in service for citizens with learning disability, Community Navigator Pilot
- More comprehensive support for carers through the Carers' Counselling Service or Carers Respite Service
- Maintaining eligibility criteria, applying the Council's interpretation of the Care Act

Carer specific support

For further details about carer specific support please the Carer Scheme descriptor which describes how we will address key priorities within the Nottingham City Joint Carers Strategy – **document 10**.

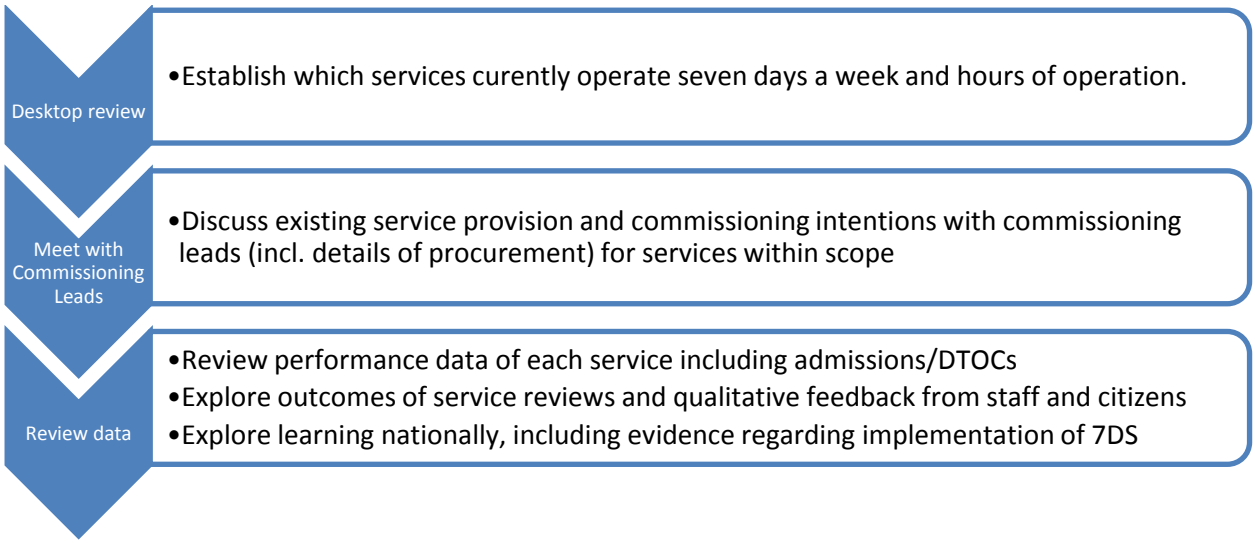
C Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate

Within Nottingham there are a number of seven day services already in place across primary care, community care, social care, mental health and secondary care. These include:-Reablement services, urgent care (crisis response), community nursing, integrated respiratory service, integrated diabetes service and some end of life services also cover 7 days to support people in their home wherever possible.

Phase 1

During 2015/16 we established a seven day services project and task and finish group to identify where further service development was required. The vision of this project is to ensure availability of appropriate health and social care services in the community as well as ensuring co-ordination to prevent hospital admission and facilitate timely discharge. The main objective is to support patients being discharged and to prevent unnecessary admissions at weekends as well improving citizen experience and outcomes.

The first phase of the project focused on reviewing demand for seven day community services, using the process outlined below.



Through this task and finish group the following services have been extended to work seven days: Community Matrons, Care Homes Nursing team (enhanced capacity); Care Co-ordinators; Integrated Community Equipment Loans Services (ICELS).

In 16/17 the social care Hospital Discharge Team and Access & Rapid Response Service will be extended to seven day services. It is expected that seven day working will commence from Q3 16/17. Development of this service expansion will be overseen through the Community Health & Social Care Integration Steering Group.

Phase 2

A Mental Health Integration Steering Group has been established, this group reports into the BCF & Integrated Care Programme Board. The main purpose of the group is to scope the current delivery of mental health services across the city and identify priorities for integration (and seven day service development). This steering group meets bi-monthly and includes representatives from the CCG, our community mental health provider, the local authority public health and Nottingham Community Voluntary Services.

The first phase of work is focussing on mapping and scoping the delivery of mental health services across primary care, secondary care, social care and the third sector. The mapping work will be aligned to ten priorities for mental health integration identified within the recent Kings Fund report "Bringing together physical and mental health: a new frontier for Integrated Care", March 2016.

D Better data sharing between health and social care, based on the NHS number

A countywide programme "Connected Nottinghamshire" is leading on information systems integration. This includes work on integrated datasets, Information Governance, underpinning infrastructure and standards; implementation of APIs and development of the Digital roadmap for Nottinghamshire. The work is progressing well with engagement across all partners and supporting the integration of services by enabling the sharing of key information. By progressing work across the city and county economies of scale can be achieved in relation to the procurement of new software solutions.

Digital road maps

As part of the overall planning for BCF and STP, Connected Nottinghamshire is facilitating the development of the Nottinghamshire Digital Roadmap which will set out the plan for 2015-2020. Planning for the Nottinghamshire Digital Roadmap commenced at a Nottinghamshire Health and Care IT summit held in November 2015, which involved members from all Connected Nottinghamshire partners including citizens and patients.

Connected Nottinghamshire members have submitted the Digital Footprint and are progressing the development of the Roadmap for submission later this year. The Nottinghamshire Digital Roadmap will be aligned to BCF and STP plans with HWB approval. This document will outline the programme vision, governance arrangements and accountabilities. It will be made available from March 2016 and will supersede the existing Connected Nottinghamshire Blueprint. The content will include:

- Access to information systems
- Integrated Digital Care Records
- Plans for exchange of data
- Plans for workflow (tasks/referral/S2&5)
- Integration tools such as MIG and the "Care Portal"
- Citizen access to records
- Mobile workforce
- Information Governance arrangements
- Benefits and evaluation/exploitation

All project boards have citizen representation, and through existing engagement forums we ensure that citizens and patients play an active part in the design of solutions. To engage the wider population we have developed a set of leaflets and posters, which are utilised across partners, and explain how information is being used. Alongside this, website privacy notices have been updated to incorporate these messages. A communications plan will be developed to support the implementation of the Digital Roadmap.

Use of the NHS number and approach to APIs

Connected Nottinghamshire is concluding Tranche 1 of implementation. Tranche 1 has laid the foundations for future integration requirements (technical enablement and information governance principles development).

Excellent progress has been made in populating systems with the NHS number. Agreement of the use of the NHS number has been in place for some time. 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 puts tracing/use of NHS number at 98% in the main providers, with the Ambulance Service matching approx. 60% 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 the local authorities and matched to NHS Numbers, which are then data quality checked and uploaded. Progress to date is 85% of current caseload records matched.

All procurements now have a set of requirements addressing the requirements for Open APIs. Recent procurements have addressed this specifically and now basing development of these APIs on the NHS England API standards document. Our position at Quarter 3 2015/16 is as follows:

Progress towards installation of Open APIs to enable information to be shared with other organisations

	GP	**Hospital**	**Social Care**	**Community**	**Mental health**	**Specialised palliative**
Progress status	Installed (not live)	Installed (not live)	Installed (not live)	Un-available	In develop-ment	In development
Projected 'go-live' date (dd/mm/yy)	01/10/17	01/10/17				

Approach to Information Governance

Connected Nottinghamshire has oversight of the Nottinghamshire Health and Social Care Records Information Group. This GP, Caldicott Guardian led group is leading the way in relation to IG requirements and ensuring Nottinghamshire has good information sharing for direct care and risk stratification. In addition to this and in line with Caldicott 2 recommendations and best practice, pseudonymised or anonymised information is used

sharing for reporting. A Nottinghamshire Data Sharing Protocol is already in place across all partners and due for review in summer 2016.

Sharing to date has been using existing messaging capability and shared access to multiple systems. This has been supplemented with the use of the Medical Interoperability Gateway (MIG) and is now moving into the key phases of MIG2 and implementation of the Care Portal.

Once the National Data Guardian review has been published the key recommendations will be considered and implemented as appropriate through the Connected Notts work stream.

As part of the overall delivery and assurance framework, benefits of the Connected Nottinghamshire programme are reported into Connected Nottinghamshire. The Programme Director provides regular updates to the Better Care fund Implementation Board and the HWB.

The table below sets out the forthcoming key milestones, along with expected and required dates. The overall plan is reported by the Connected Nottinghamshire Programme Director and monitored by the Connected Nottinghamshire Board. The milestones are inter-organisational some require cross-organisational delivery.

Milestone	**Date**
MIG2 sharing of additional datasets across Health and Care live	October 2016
Electronic workflow (S2,3 & 5) phase one live	October 2016
Nottinghamshire Care Portal 1. Phase one (estimated February 2016-November 2016) a. NUH, SFHFT, NHCFT connectivity (through trust integration engine connected between Highway, Rhapsody and Ensemble respectively). b. Commercial arrangements in place for phase one providers c. IG arrangements in place d. MIG connectivity into CareCentric e. CareCentric viewer available for Care Co-ordinators and Call for Care f. GP direct connect phase one - pilot (12 practices?) g. Structured messaging in place for ITK transit (e-discharge and letters) h. EPaCCS transition i. Governance arrangements in place j. Benefits framework in place 2. Phase two (estimated January 2016-October 2017) a. Nottinghamshire County Council connectivity (via TotalMobile connect interface?) b. Nottingham City Council (connection via Liquid Logic)	January 2016 – October 2017

E 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

The Joint Assessment and Care Planning Task and Finish group is currently working on the following outputs:

- A Transfer of Care (ToC) document to follow the patient from hospital discharge into community health and social care services. The document is being finalised for a paper based pilot on two hospital wards in Q1 & Q2 2016/17.
- Alongside the piloting of the paper based ToC document a dataset is being defined to enable the CareCentric Portal to provide this electronically when it goes live in Q3 2016. This dataset will be ready for the Connected Notts Programme to include in their roll-out plan.
- A review of the care plans and folders kept in citizen's homes has been undertaken and was completed in February 2016. The standardised contents list and associated Information Governance requirements will be signed off at the next task and finish group in April 2016 and taken to the Community Health and Social Care Integration Steering Group for approval to be implemented in Q1 and Q2 of 2016/17.

Additionally in Q1 2016/17 the scope and workplan of the project will be revised to include the minimum and further KLOE conditions. Initial work will include mapping the citizen/patient pathway through services identifying where joint assessments and care planning occur and what action needs to be taken to meet the KLOE conditions. Learning from the current outputs (detailed above) will be applied across the pathway and will utilise the CareCentric portal as it rolls out. The revised workplan will be presented to the CH&SC Integration Steering Group for approval in early Q2.

The Mental Health Integration Steering Group is due to agree the workplan priorities in Q1 2016/17; and dementia services have already been agreed as priority in line with the key priorities outlined within the Nottingham City Mental Health and Wellbeing Strategy – Wellness in Mind – **document 11**. It will also be decided if work on joint assessment and care planning in relation to dementia services will be a task and finish group reporting to the Mental Health Integration Steering group, or if it will be implemented through the workplan for the Joint Assessment and Care Planning Task and Finish group.

F Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

As outlined in Section 4, our BCF/Integrated Care Programme Board and work streams continue to include representation from providers including our acute, community and mental health trusts as well as third sector and social care providers. A number of these providers also sit on the Nottingham City Health and Wellbeing Board and the BCF/Integrated Care Programme Board.

An independent evaluation of the Integrated Care programme highlighted the robust governance arrangements in place to support decision making and management of risks. The Health and Wellbeing Board receive regular updates on integrated care as a key priority within the health and wellbeing strategy.

Providers and wider stakeholders continue to be engaged to discuss strategic commissioning intentions through engagement events and contract negotiations. Discussions focus on system impact and ensuring sustainability for both health and

social care services. For example we are currently developing a plan to integrate appropriate mental health services into Care Delivery Groups; this will ensure holistic care for citizens as well as safeguarding essential interventions.

Risks are managed through the Integrated Care / BCF Programme Board; impact of changing one part of the system on the rest of the system can be managed proactively by the multi-agency Board. For example, in agreeing the reduction in non- elective activity we have been able to give assurance that community capacity and operational processes are robust enough to manage the change in activity. Through the reporting of outputs from relevant work streams gaps and concerns could be addressed in a timely manner.

An overarching objective of the Integrated Adult Care Programme is to transform citizen experience of Health and Social Care provision in the City. Early engagement work within the programme informed the design of the key programme work streams and aims of the integrated care model. We will continue to engage throughout the implementation of the integrated care model using the sharing the vision model developed by colleagues in Nottingham City Council. In essence sharing the future is an approach which shares leadership, decision making, ideas and information, views and experiences with citizens. Further details are available in **document 12.** Additionally Healthwatch are represented at our HWB and BCF/Integrated Care Programme Board.

G Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

The investment in NHS commissioned out of hospital services, including social care is clearly set out in the summary and expenditure plan tabs of the BCF planning return template.

Our BCF Programme Board has considered a risk sharing arrangement for out of hospital services and concluded that it is not required at this time due to our strong working relationships and performance against the BCF non-elective activity metric in 2015/16.

The focus of our BCF plan has, and will continue to be on out of hospital services in the community to support the shift in activity, prevent avoidable admissions, facilitate system flow and improve person-centred co-ordinated care. The key work steams within our integrated care model are all focused on out of hospital services including social care and primary care. Our level of investment by scheme is summarised in the table below.

Scheme	Investment in NHS commissioned out of hospital services	
	2015/16 investment (£000)	2016/17 allocation (£000)
Access & Navigation	787	1,199
Assistive Technology	400	475
Carers	667	714
Capital (DFG)	N/A	N/A
Co-ordinated Care	1,349	1,144
Independence Pathway	7,672	7,341
Programme Management	166	305
City Total	11,041	11,178

H Agreement on local action plan to reduce delayed transfers of care (DTOC)

Across Nottingham Delayed Transfers of Care (DTOCs) are managed through the System Resilience Group (SRG) and monitored by the BCF Programme Board.

Work to reduce DTOCs across the system is led by the work stream two of the Urgent Care Programme Office which reports to the System Resilience Group. Links are established between SRIG and the BCF / Integrated care programme Board.

A system wide resilience plan has been developed which includes our approach to improving DTOCs. Providers in our system have produced a self-assessment of their impact change model for deducing DTOCs; this is included as **document 13.** The self-assessment was produced using a tool provided by the national Emergency Care Improvement Programme and identifies for each provider the “high impact” change they are implementing, progress to date, remaining tasks, timescales and identifies how we will know it has been successful.

We have used the information provided within the self-assessment to highlight the key findings about the progress to implement each high impact intervention for each provider; NUH; CityCare; Nottingham City Council Social Care :-

- Two of the three providers have identified that plans are in place to implement discharge planning with a commitment to fully implement these approaches by August 2016. The community services provider will be approached to confirm its plans for early discharge planning during Q1 16/17.
- Systems to monitor patient flow across each provider have been implemented with subtleties in the level of sophistication of these systems. A number of key tasks have been identified to improve these systems in early 2016/17 this includes a system wide consensus on the appropriateness of Medically Safe for Transfer (MST) decision and to ‘sign off’ the 120 delays.
- The acute provider has a multi-disciplinary multi-agency team in place to facilitate discharge; within the community multi-disciplinary locality based teams operate across the city with social care input.
- A system wide pilot has been implemented for six months to prove the concept of transfer to assess, there is full engagement across each provider and the CCG has oversight over the monitoring and develop of this pilot (along with the consequential impact on system flow and DTOCs). An external evaluation of this pilot has been commissioned; this will be used to inform the decision about extension of this approach.
- The acute provider have agreed to review 7 day working for the Supported Transfer of Care (STOC) team by the end of Q2 16/17. The urgent care and reablement services within the community already operate 7 days and through the community health & social care integration group (with BCF funding) the social care hospital discharge team will move to seven day working by Q3 16/17.
- Trusted Assessors is considered to be a mature approach in the acute provider; during 16/17 the community provider will continue to roll out its holistic worker competency framework and this will be trialled across adult social care.
- The leaving hospital policy is understood, but there is agreement that this needs to be implemented in a systematic and consistent way. This will be re-launched during Q1-Q2 16/17.

- Work to enhance health in care homes through the Care Homes Vanguard programme will be supported by each provider.

Work is also underway to develop a framework for measuring 'transfer of care' activity and performance, DTOCs will be a key feature of this. To support this we plan to:

- Conduct a local deep dive analysis into reasons for the recent increase in DTOCs across all providers, NUH, CityCare, Nottinghamshire Healthcare Trust and Community Health Partnerships recognising that the issues for individual providers may vary.
- Produce a local situation analysis which will include a review of interventions against national best practice.
- Co-produce with providers a local DTOC action plan for 2016/17 which supports the system wide action plan.

Our BCF Programme Board has considered a risk sharing arrangement for DTOCs and concluded that it is not required at this time due to our strong working relationships and need for local management at a System Resilience Group level.

6 Financial risk sharing and contingency

The 2015/16 BCF plan established a financial risk sharing mechanism that has operated successfully in the first year of the pooled fund. Our programme board has considered the need for a risk share agreement in 2016/17 in relation to NEA activity and DTOC activity and concluded that it is not required at this time due to strong working relationships and progress made during 2015/16.

We will continue to monitor performance against the NEA and DTOC targets on a monthly basis through the BCF Finance & Performance Group, reporting to the BCF & Integrated Care Programme Board and Commissioning Sub-committee of the Health & Wellbeing Board. This is in addition the CCG continuing to manage activity variances through contractual processes. 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 to the system. 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.

As part of our broader plans for integration and the move to full integration of health & social care by 2020 as outlined in the five year forward view we are exploring risk share arrangements for an adult pooled budget in future years.