Better Care Fund 2019/20 Template

3. Summary

Selected Health and Wellbeing Board: Nottingham

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,439,908	£2,439,908	£0
Minimum CCG Contribution	£23,462,053	£23,462,053	£0
iBCF	£14,564,610	£14,564,610	£0
Winter Pressures Grant	£1,550,028	£1,550,028	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	£42,016,599	£42,016,599	£0

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£6,667,250
Planned spend	£9,829,113

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£12,724,637
Planned spend	£12,724,637

Scheme Types

Assistive Technologies and Equipment	£567,300
Care Act Implementation Related Duties	£0
Carers Services	£714,040
Community Based Schemes	£61,500
DFG Related Schemes	£2,339,908
Enablers for Integration	£25,244
HICM for Managing Transfer of Care	£755,324
Home Care or Domiciliary Care	£1,035,822
Housing Related Schemes	£77,000
Integrated Care Planning and Navigation	£17,762,853
Intermediate Care Services	£16,116,245
Personalised Budgeting and Commissioning	£0
Personalised Care at Home	£0
Prevention / Early Intervention	£2,422,372
Residential Placements	£114,546
Other	£24,445
Total	£42,016,599

HICM >>

		Planned level of maturity for 2019/2020
Chg 1	Early discharge planning	Established
Chg 2	Systems to monitor patient flow	Established
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Established
Chg 4	Home first / discharge to assess	Established
Chg 5	Seven-day service	Established
Chg 6	Trusted assessors	Established
Chg 7	Focus on choice	Established
Chg 8	Enhancing health in care homes	Established

Metrics >>

Non-Elective Admissions
Delayed Transfer of Care

Go to Better Care Exchange >>

Residential Admissions

		19/20 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	981.7612275

Reablement

		19/20 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	0.8

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	Yes

Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
	PR8	Yes
Metrics	**PR9**	Yes

4. Strategic Narrative

(a) Person-centred outcomes

Self-care and the promotion of independence has been a key priority under the Nottingham City Health and Wellbeing (HWB) Strategy since 2016 as part of the development of Healthy Culture. This has included the development of Community Together Surgeries, social prescribing, piloting community pioneer programmes, self-care hubs, and a joint web-based directory of services (AskLiON). The HWB strategy is in its final year, but progress continues to be monitored with developments over the coming year, including:

- Root cause analysis of Delayed Transfers of Care (DTOC) to further improve Reablement outcomes;
- Sustaining the drive to increase the number of citizens living independently at home through the Assistive Technology (AT) Service, including the roll out of MyCOPD;
- Development of a 'wellbeing wheel' to help citizens, carers and the workforce to access information on the AskLiON directory easily and develop a person centred care plan that includes community connections alongside more traditional services and activities.

To complement the HWB Strategy (2016-2020), the Nottinghamshire Integrated Care System's (ICS) prevention, person and community centred approaches vision is to maximise independence, good health and well-being throughout people's lives. The ICS has developed a strategy that will focus on changing behaviours at the level of the individual, community, workforce and whole system, supported by an action plan which will provide a clear, evidence-based and locally modelled system-wide programme to deliver the vision.

There are five key programmes of work on prevention, person and community-based approaches. The goal is for place-based, person-centred services delivered in local communities through partnership with the public, community, voluntary and private sectors.

Primary Care Networks (PCNs) and the Integrated Care Partnership (ICP) are a new driving force for integration of care. A social prescribing and community connectivity group on a ICP & HWB footprint has been developed to drive the objectives of the ICS strategy. The group's focus is on the following key elements of the promotion of self-care and independence:

- Community development – development of locally accessible forums for community leaders and local citizens/'patients' to meet with public service providers and local businesses, sports, cultural, spiritual and retailers on a regular basis to build more confident, capable and inclusive communities;

- Community asset mapping – directory of local resources and build on these existing assets so that individuals can be signposted /supported to access appropriate activities, groups, facilities to achieve their goals within their own localities;

- Social prescribing/Link Worker implementation – development and support for the introduction of the Primary Care Networks (PCNs) Link Worker workforce and integration with existing social prescribing services.

The Council has continued to develop its arrangements to promote independence and choice in line with the Wellbeing Principle and duties to prevent and delay the need for care. In November 2018, the Council approved its new 'Better Lives, Better Outcomes' (BLBO) strategy for adult social care, setting out four main themes to help prevent the development of care needs and to support choice and independence:

- Prevention: promoting healthy lifestyles and intervening early when people's wellbeing is at risk to avoid crisis and loss of independence;
- Community Connections: ensuring citizens can connect to the resources and support in their local neighborhoods, ensuring no one is socially isolated and lonely;
- Independent Lives: supporting personal and community resilience, strengths and resources, reducing dependence on council funded support where possible;
- Choice and Control: seeing the citizen in the driving seat, shaping solutions around the outcomes that matter for individuals.

Developments in support of person centred outcomes, prevention and choice delivered in line with the HWB and BLBO strategies include:

- Information and advice – a citywide information and advice online directory ('AskLiON') has been implemented incorporating the self-care directory developed during the pilot. AskLiON supports signposting advice and guidance to encourage self-management and to delay and reduce unnecessary access into traditional health and care support. The directory supports information for preventative self-care and restorative self-care for self-management. A "wheel" tool is being assessed to further develop the resources available to citizens to generate their own self-care plans and potentially to generate their own social prescriptions;

- Integration Accelerator Pilot – new arrangements to enable the delivery of more integrated assessment and support planning across health and social care services are currently being piloted to avoid the duplication of activity and to improve outcomes for citizens. The aim of the pilot is to improve people's outcomes and their experience of accessing health and care services, whilst also helping to increase efficiency and manage demand though joined up working, improved communication and the avoidance of duplication. The pilot has trialled joined-up assessments and reviews, joint care and support plans, and integrated personal budgets;

- Personal budgets – our personalisation hub supports citizens to access and use health and social care budgets effectively. Accessing the hub allows citizens to tap into advice and support on a range of issues associated with personal budgets (e.g. on becoming an employer, support planning, managed accounts, etc), as well as access to card accounts and other services. The hub also monitors use of personal budgets to ensure that citizens receive the support they need to work through any difficulties they might experience;

- Strength-based practice – our default approach of identifying individuals' strengths and assets that can support their independence has become embedded practice through the roll out of training, tools and new ways of working across ASC. Strength based approaches are deployed across pathways and services, including the Nottingham Health and Care Point, the Reablement Service, Occupational Therapy and Community Together Surgeries;

- Community Together Surgeries (CTS) – CTS offer regular sessions available at a range of community venues available via appointment or drop-in. CTS provide an opportunity for citizens to access information, advice and signposting, as well as assessment and support under the Care Act where this is needed. Discussions with people are strengths-based and work to the '3 conversations' model. Over 60% of people attending CTS are connected to services and support to meet their individually identified needs through this preventative approach without the need for social care assessment and the provision of social care services. The CTS approach is enhanced by being sited within community centres and alongside social eating opportunities where other community services and groups are also present. Information and connection to AT services, home safety checks, welfare rights advice, housing services and opportunities for physical activity / recreation are some of the complementary services accessible via CTS. An occupational therapist is also always available at the CTS to advise on equipment, aids and adaptations to maximise peoples' independence and help prevent, reduce or delay need;

- Support for carers:

(i) The Carers Hub is an integrated service providing access to information, advice and support for people in caring roles across Nottingham and Nottinghamshire. The service completed 1,200 carers assessments and provided support for 1,842 carers in 2018/19 (a 12% and 14% increase on 2017/18 respectively) to help carers to sustain their caring roles and reduce premature reliance on social care services. The Carers Respite service (for carers where the cared-for person does not meet Adult Social Care thresholds) has also enabled 284 carers to take the breaks they needed, avoiding carer breakdown. Carers were involved in every stage of developing these services, including designing the service model and scoring the bids for the services.

(ii) Action for Young Carers provides integrated, holistic support young carers and their families. The service offers individual and family assessments, so that the young carer's needs are considered across Adults and Children's Social Care as well as with Health and Education. The service offers age-appropriate advice and support for the young carer, as well as opportunities for breaks from caring responsibilities and social experiences other young people might take for granted. The service supported 391 young carers in 2018/19.

(iii) An updated Carers Strategy led by NCC and GNCP is currently being developed, with carers from a wide range of groups across the City feeding in to the strategy. The

Strategy will be approved and built upon through the ICP to ensure that all partner organisations will be aware of and fulfil their role in supporting carers.

Nottingham and Nottinghamshire's visions for health and social care integration are closely aligned. As we move towards a focus on place-based systems of care, our work through the Nottingham and Nottinghamshire ICS increasingly reflects a cross-boundary approach. We 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. Steps have already been taken across Nottinghamshire to continue to transition towards this person-centred and preventative model of health and social care. What matters most to local people, commissioners and providers are the improvements we make together for the benefit of patients and service users by optimising choice and independence wherever possible.

(b) HWB Level

(i) Your approach to integrated services at HWB level

The Nottingham City Integrated Care Partnership (ICP) will bring together health and care providers and local commissioners to work together to improve services for our population, and to make sure that they are sustainable. The City of Nottingham is a unique place that merits a special focus on the health of its citizens. We know that we have many challenges in Nottingham that we can only address by the organisations that can have an impact on people's lives really working together. The ICP development group are currently working with partners including Nottingham City Council, Nottingham CityCare, Nottingham City GP Alliance, NHS Nottingham City CCG, Nottingham Community and Voluntary Service (NCVS), Framework, Nottingham City Homes, Nottingham University Hospitals and Nottinghamshire Healthcare.

General practice is key to the development of Integrated Care; it is anticipated the Primary Care Networks (PCNs) and Nottingham City GP Alliance (NCGPA) will support the development of new care models required within the ICP and ICS plans with general practice being at the heart of these.

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.

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.

Key features of our approach 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.

Addressing health inequalities is a central focus of the City's Health and Wellbeing Strategy 'Happier, Healthier Lives'. Our strategy sets clear aims of increasing life expectancy in Nottingham and making it one of the healthiest big cities, as well as reducing inequalities in health by targeting neighbourhoods with the lowest levels of healthy life expectancy.

This priority is reflected in Nottingham's Adult Social Care Strategy 'Better Lives, Better Outcomes', which sets out to address health inequalities through prevention (one of four major themes within the strategy) and by supporting access activities that help to prevent, reduce or delay the need for support in line with principles set out in the Care Act.

Our strength based approach to practice is working well to connect citizens to physical activity and social opportunities in their local communities, and both areas have demonstrable benefits to citizens' health & wellbeing. Strength based working is evident throughout Nottingham's practice, but most visible in the Community Together Surgeries which benefited from the release of a CCO for 6 months to map opportunities & develop social care practice in this area.

(ii) Your approach to integration with the wider service

A range of measures and approaches have been included in local strategies (and are in delivery) to ensure the availability of suitable accommodation and to offer home environments that will enable people to live safely and independently.

Major Adaptations:
The DFG is used to fund the capital spend of the Major Adaptations Agency. This service organises adaptations to the homes of people with long term conditions and disabilities with the aim of maximising their independence and enabling them to continue to live safely at home. Adaptations are arranged in line with an assessment completed by an occupational therapist.

Adaptations include level access showers, ramps, kitchen alterations, widening doorways, and specialist equipment including stair lifts, hoists and through floor lifts.

Major Adaptations covers owner occupied properties, as well as tenancies let by social and private landlords. The service enables people to stay at home, to become more independent, and reduce the support they require from carers.

Preventative Adaptations Service (PAD):
PAD is a free service for all people aged 60 and over that offers a comprehensive range of minor adaptations to reduce the risk of injury and increase safety within the home. The main aims of the service are to:

- Increase safety in the home for older people;
- Reduce the occurrence of falls;
- Facilitate timely discharge for people leaving hospital.

Adaptations are determined in accordance with the outcome of individual assessments and can include grab rails, additional stair rails, replacing high steps with shallow steps, threshold strips, and other measures. The service also makes fire safety referrals.

Integrated Community Equipment Loan Service:
ICELS is a fully integrated system (commissioned in partnership between Nottingham City Council, Nottinghamshire County Council and Greater Nottingham CCP) that delivers around 36,000 items of equipment annually to City residents and people registered with a City GP.

ICELS loans equipment in line with assessments conducted by an occupational therapist. Equipment is provided to help people to live independently by maximising their mobility and/or their ability to self-care, and also to assist family or paid carers to support people in their own homes.

Performance information collected across Major Adaptations, PAD and ICELS indicates that adaptations increase citizens' independence while reducing avoidable admissions to residential care and hospital, carer stress and reliance on care services.

Integrated Assistive Technology (AT):
Our AT budget includes a capital element funded through the DFG. This provides:

- Purchasing sensors, detectors and alarms;
- Service costs for monitoring systems;
- Lease costs / data system charges for telehealth equipment.

AT is embedded at the Nottingham Health & Care Point (an integrated triage function supporting access to appropriate services) and in teams' practice. Both traditional AT solutions and more innovative options (including the activity assessment 'Just Checking' and safer walking technology) are offered to promote independence and reduce reliance on health and care services. Integrated planning and delivery meetings are used to develop improved housing and AT solutions in line with these aims and to reduce unnecessary admissions to hospital and residential care.

Housing Sufficiency:
The BLBO strategy recognises a good home as underpinning the independence and wellbeing of people who live in the City. The strategy commits to the principle that all adults with care needs should have the opportunity to have their own home, and should only live in residential care where all other options have been exhausted. It also commits to develop solutions to support young people with disabilities to find a home and to have the skills or support to manage it.

Nottingham's Housing Strategy 'Quality Homes for All' sets out the commitments that the Council and its partners have made in relation to housing. It specifically recognises the importance of appropriate housing for people with care and support needs. The strategy commits to improve access to suitable housing, including through the development of bungalows and lifetime homes for older people and accommodation suitable for use as independent living for younger adults.

Access to suitable accommodation has increased significantly over the past year through engagement with accommodation providers and developers as part of the drive to promote independent living for people with care needs. Work is also in progress to forecast the future accommodation requirement for older adults and adults with disabilities and to plan the development of suitable solutions (with input from key partners including NCH) through a more detailed Housing Sufficiency Strategy for the City. The activity included within this strategy also centres on the principle of promoting independent accommodation as the primary living arrangement for people are care needs, to tie with arrangements for the provision of enabling support set out in BLBO.

We see the right home environment as key to people achieving good outcomes, and we will ensure that housing needs are a central consideration as part of our approach to assist people to maintain or re-establish their independence.

(c) System-level alignment

"As an accelerator site Nottinghamshire has developed two Integrated Care Systems (ICS) - Nottinghamshire ICS and South Yorkshire and Bassetlaw ICS. The Nottinghamshire ICS encompasses both local authorities (Nottingham City and Nottinghamshire County), Nottingham and Nottinghamshire Clinical Commissioning Groups, health providers including Nottingham University Hospitals NHS Trust, Sherwood Forest NHS Foundation Trust, East Midlands Ambulance Service, Nottingham CityCare Partnership and Nottinghamshire Healthcare NHS Foundation Trust.

The Nottinghamshire ICS provides strong local leadership to develop system strategy and key deliverables for Integrated Care Partnerships (ICPs) and Primary Care Networks (PCNs) to implement population health management approaches, whilst tackling the systemic challenges that face health and social care.

There are three ICPs across the ICS: South Nottinghamshire, Mid Nottinghamshire, and Nottingham City. ICPs operate on a place based footprint as a partnership of providers, health and care, with district / local level partnership working to deliver the ICS priorities.

Governance and accountability arrangements remain in place as outlined in our BCF 2017/19 plan with the Health & Wellbeing Board being ultimately responsible for maintaining oversight of the health and social care system. As a statutory body it has governance at member and Chief Executive Officer level.

The Health and Wellbeing Board Commissioning Sub-Committee (established in April 2015) has delegated authority for decision making on commissioning decisions in relation to the BCF. It is chaired by a lead member from the Nottingham City Council with Executive level membership from partnership organisations. This committee meets on a quarterly basis unless extraordinary meetings are required.

The BCF Delivery Group, which reports into Health and Wellbeing Board Commissioning Sub-Committee meets on a monthly basis to provide continuing oversight for the development and delivery of the plan. There exists a strong commitment from all partners to ensure the BCF conditions are met and evaluated.

Annual assurances are also provided to the Greater Nottingham Joint Commissioning Committee, which has executive level membership from partner organisations (Local Authority and Health) to provide assurance that risks associated with the BCF are being managed effectively, and that the governance arrangements that are in place to manage the operation of the BCF are robust and support the effective and efficient management of the fund.

The principles and purpose of the BCF are complementary to the priorities across the ICS. We have reflected the future priorities within the NHS Long Term Plan and the priorities of the ICS in the development of this year's BCF Plan, and aligned these to existing governance structures to ensure deliverability.
Nottinghamshire ICS priorities:

- Re-design and integrate clinical and care pathways to better meet the needs of the local population;
- Develop population health management approaches that facilitate the integration of services;
- Work with key system partners and stakeholders including patients and citizens and their democratic representatives, health and care staff, local government and the voluntary sector to achieve these aims;
- Take collective responsibility for managing financial and operational performance, quality of care and health and care outcomes;
- Implement new methods of payment that support integration of services and population health management approaches, whilst enabling delivery of a shared system control total;
- Create more robust cross-organisational arrangements to tackle the systemic challenges that the health and care system are facing;

- Act as a leadership cohort, demonstrating what can be achieved with strong local leadership, operating with increased freedoms and flexibilities.

Some of the key examples of the BCF projects linked to these priorities are:
- Over the last year the Care Co-ordination service has evolved and developed to provide Primary Care Networks with the ability to proactively identify care gaps in its population. They are responsible for facilitating multi-disciplinary team meetings between Primary Care, Community Services Teams and Social Care Assessment Services to citizens needs and goals are agreed jointly.

As the Plan progresses through the year, work on delivering a single MDT model across the ICS footprint will continue, and Care Co-ordinators will become key enablers for self-care and long term condition management across Nottinghamshire.

- Our health and social care system is delivering one of the national pilots of Integrated Personal Commissioning and further integrating health and social care assessments and support plans through this work. In addition, there is a focused health and social care partnership has been formed to develop social prescribing in the City, underpinned by joint plans, integrated training offers (including health, care and voluntary sector) and operational delivery, as well as jointly agreed criteria and expected outcomes. Both of these areas of work feed into the ICP and wider ICS.

- The Housing to Health (H2H) project supports three Housing and Health Coordinators (HHCs) to integrate housing support within the local healthcare system.
The HHCs have well established links with the local hospitals (with one HHC now placed full-time as part of the Integrated Discharge Team), mental health hospitals and step-down units, and community-based health and care staff.
The Housing to Health project has significantly speeded up the traditional housing process – the median time for the H2H rehousing process was 64 days in 2018/19, compared to the median letting time of 270 days for similar types of Nottingham City Homes properties for an individual with a medical priority on the general housing register.

In 2018/19, 46% of cases (52 individuals) were occupying high-demand NHS or social care beds, with housing issues causing a delayed transfer of care (DTOC). The H2H project reduced the total number days of delayed transfer of care in residential health or social care facilities by 8,795 days.
The remaining 54% of cases were early intervention, where clients were referred from community healthcare staff (60 individuals). It is estimated that 40 cases were at risk of future hospital admission due to the unsuitability of their home and associated health risks due to poor health. Data from Nottingham University Hospitals shows that early intervention is effective, with this group demonstrated a reduction in the number, length and cost of hospital admissions following the H2H intervention.

- An established Transforming Homecare Strategic Group, with membership from senior health and social care teams, tasked with oversight and delivery of something different to tackle the estimated 5% gap in capacity to provide homecare. The Transforming Homecare

Group will use current working groups to ensure that all the key people are in the same place, making change happen, with one voice. This work plan includes:

- Review and develop system pathways to address the dependency and complexity in those requiring homecare reduce duplication e.g. during planning, oversight and monitoring.
- Address the isolation, progression and prestige associated with working in homecare.
- Create Health and Social Care career development opportunities.
- Progression of the ideas to reduce the number of large care packages with the support of partners across the system.

- Carers are integral to the health and care system and to achieving the best outcomes for people they care for, and we recognise the vital importance of supporting caring relationships to our City. A joint Carers Strategy is currently being refreshed through contributions from key partners across the health and social care system (including Greater Nottingham CCP, Nottingham University Hospitals NHS Trust, Nottingham City Council and Nottingham Council for Voluntary Service) and from a range of carers groups representing different regions of the City and interests (e.g. mental health, learning disabilities, dementia, substance misuse, etc).

Better Care Fund 2019/20 Template

5. Income

Selected Health and Wellbeing Board: Nottingham

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Nottingham	£2,439,908
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,439,908**

iBCF Contribution	Contribution
Nottingham	£14,564,610
Total iBCF Contribution	**£14,564,610**

Winter Pressures Grant	Contribution
Nottingham	£1,550,028
Total Winter Pressures Grant Contribution	**£1,550,028**

Are any additional LA Contributions being made in 2019/20? If yes, please detail below	No

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

CCG Minimum Contribution	Contribution
NHS Nottingham City CCG	£23,462,053
Total Minimum CCG Contribution	**£23,462,053**

Are any additional CCG Contributions being made in 2019/20? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
Total Addition CCG Contribution	**£0**	
Total CCG Contribution	**£23,462,053**	

	2019/20
Total BCF Pooled Budget	**£42,016,599**

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

Better Care Fund 2019/20 Template

6. Expenditure

Selected Health and Wellbeing Board: Nottingham

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,439,908	£2,439,908	£0
Minimum CCG Contribution	£23,462,053	£23,462,053	£0
iBCF	£14,564,610	£14,564,610	£0
Winter Pressures Grant	£1,550,028	£1,550,028	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	£42,016,599	£42,016,599	**£0**

Required Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£6,667,250	£9,829,113	£0
Adult Social Care services spend from the minimum CCG allocations	£12,724,637	£12,724,637	£0

Link to Scheme Type description

						Planned Outputs		Metric Impact				Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Access & Navigation	Co-ordinate care to deliver seamless access to services, promotion of self-care and independence and pro active identification of care gaps	Integrated Care Planning and Navigation	Care Coordination				High	Low	Medium	Medium	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£877,783	Existing
2	Access & Navigation	Ensuring local people receive the right level of advice and support at initial contact	Integrated Care Planning and Navigation	Single Point of Access				Medium	Not applicable	Low	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,018,443	Existing
3	Integrated Care	An integrated specialist short term care and rehabilitation within the community to prevent unnecessary hospital admission in a crisis situation and to enable patients/citizens to regain their independence and to recover from an acute illness requiring a hospital stay, condition or life event	Intermediate Care Services	Other	Includes all subtypes	Planned service capacity	49,181.0	High	High	High	High	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£5,781,292	Existing
4	Integrated Care	Supporting local people to achieve and retain the maximum level of independence by continuing to be able to live within their local community	Intermediate Care Services	Other	Homecare packages (81,207) plus Integrated Care Teams costs	Hours of Care	81,207.0	High	Medium	High	Medium	Social Care		LA			Local Authority	Minimum CCG Contribution	£6,425,674	Existing
5	Integrated Care	Supporting local people to achieve and retain the maximum level of independence by continuing to be able to live within their local community	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				High	Medium	High	Medium	Community Health		LA			Local Authority	Minimum CCG Contribution	£372,385	Existing
6	Integrated Care	Supporting local people to achieve the maximum level of independence, therefore either avoiding hospital admission or supporting recovery following admission	Intermediate Care Services	Reablement/Rehabilitation Services		Hours of Care	87,271.0	High	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£2,887,949	Existing
7	Primary Care	A local Primary Care incentive scheme which encompasses a number of requirements including proactive care management of it population	Prevention / Early Intervention	Other	Physical Health & Wellbeing			High	Medium	Medium	Medium	Primary Care		CCG			NHS Community Provider	Minimum CCG Contribution	£2,422,372	Existing
8	Facilitating Discharge	To continue to work in partnership to create a system wide integrated discharge function within acute care for local people	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge				Medium	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£755,324	Existing
9	Facilitating Discharge	To continue to work in partnership to create a system wide approach to create appropriate services and support for local people with mental health	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Not applicable	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,637,247	Existing
10	Programme Management	Dedicated resource to support the delivery of the BCF	Enablers for Integration	Integrated workforce				Not applicable	Not applicable	Not applicable	Not applicable	Other	Programme Management	CCG			CCG	Minimum CCG Contribution	£25,244	Existing
11	Assitive Technology	Digital strategy in place to ensure local people have access to the most up to date assistive technology to promote their independence	Assistive Technologies and Equipment	Other	Telecare, Telehealth & Integrated jointly commissioned response service			Medium	Medium	Medium	Medium	Community Health		Joint	46.0%	54.0%	Local Authority	Minimum CCG Contribution	£334,400	Existing
12	Assitive Technology	Digital strategy in place to ensure local people have access to the most up to date assistive technology to promote their independence	Assistive Technologies and Equipment	Other	Dispersed Alarm Service			Medium	Medium	Medium	Medium	Community Health		Joint	46.0%	54.0%	Local Authority	Minimum CCG Contribution	£115,900	Existing
13	Assitive Technology	Digital strategy in place to ensure local people have access to the most up to date assistive technology to promote their independence	Assistive Technologies and Equipment	Community Based Equipment				Medium	Medium	Medium	Medium	Community Health		CCG			Private Sector	Minimum CCG Contribution	£17,000	Existing

14	Carers	Partnership working with the third sector to ensure local carers (including children and young people) have access to appropriate support	Carers Services	Other	Carers Advice and Support & Respite Service			Medium	Low	Medium	Not applicable	Community Health		Joint	59.0%	41.0%	Private Sector	Minimum CCG Contribution	£714,040	Existing
15	Housing Health	Dedicated housing specialist to support patients who are inappropriately housed, where this is putting them at risk of hospital admission or causing a delay	Housing Related Schemes					High	High	High	High	Community Health		CCG			Local Authority	Minimum CCG Contribution	£77,000	New
16	Facilitating Discharge	Reablement/ intermediate care places in residential care/nursing	Residential Placements	Care Home		Placements	3.0	Medium	High	Not applicable	Medium	Social Care		LA			Local Authority	Winter Pressures Grant	£114,546	Existing
17	Coordinated Care	Additional reablement/care in own home	Home Care or Domiciliary Care			Hours of Care	4,995.0	Medium	High	High	High	Social Care		LA			Local Authority	Winter Pressures Grant	£390,578	Existing
18	Facilitating Discharge	Dedicated discharge team embedded in domiciliary providers	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	High	High	High	Social Care		LA			Local Authority	Winter Pressures Grant	£338,160	Existing
19	Facilitating Discharge	Additional domiciliary care packages (not reablement)	Home Care or Domiciliary Care			Hours of Care	29,006.0	Medium	High	High	Low	Social Care		LA			Charity / Voluntary Sector	Winter Pressures Grant	£645,244	Existing
20	Facilitating Discharge	Work with voluntary/community sector to reduce DTOC	Community Based Schemes					Medium	High	Low	Low	Social Care		LA			Charity / Voluntary Sector	Winter Pressures Grant	£61,500	Existing
21	Coordinated Care	There is a strong commitment within Nottingham City to integrate care for Adults with long term conditions and the frail elderly to ensure future demand both new and increased complexity can be met within existing resources. This is to ensure citizens receive care that meets both their social care and health outcomes avoiding unnecessary hospital admissions and shortening hospital stays	Integrated Care Planning and Navigation	Other	Fee increase to stabilise the care provider market			Medium	Medium	Medium	Low	Social Care		LA			Local Authority	iBCF	£13,518,835	Existing
22	Independence Pathway	Social care reablement and early intervention OT	Intermediate Care Services	Reablement/Rehabilitation Services		Packages	1,200.0	Medium	High	High	High	Social Care		LA			Local Authority	iBCF	£1,021,330	Existing
23	Access & Navigation	Citizen Triage - Nottingham Health and Care Point	Other		Post to aid transfer to private homecare			Low	High	Low	High	Social Care		LA			Local Authority	iBCF	£24,445	Existing
24	Capital Grants (DFG)	Major adaptations to ensure appropriate housing for people with care and support needs	DFG Related Schemes	Adaptations				Medium	Low	Medium	Medium	Social Care		LA			Local Authority	DFG	£2,003,908	Existing
25	Capital Grants (DFG)	Community equipment to promote independence at home	DFG Related Schemes	Adaptations				Medium	Low	Medium	Medium	Social Care		LA			Local Authority	DFG	£336,000	Existing
26	Capital Grants (DFG)	Digital strategy in place to ensure local people have access to the most up to date assistive technology to promote their independence	Assistive Technologies and Equipment	Other	Combined			Medium	Medium	Medium	Medium	Social Care		LA			Local Authority	DFG	£100,000	Existing

^^ Link back up

Scheme Type	Description	Sub Type
Assistive Technologies and Equipment	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Digital participation services).	Telecare Wellness Services Digital Participation Services Community Based Equipment Other
Care Act Implementation Related Duties	Funding planned towards the implementation of Care Act related duties.	Deprivation of Liberty Safeguards (DoLS) Other
Carers Services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. This also includes the implementation of the Care Act as a sub-type.	Carer Advice and Support Respite Services Other
Community Based Schemes	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood level (eg: Integrated Neighbourhood Teams)	
DFG Related Schemes	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes.	Adaptations Other

Enablers for Integration	Schemes that build and develop the enabling foundations of health and social care integration encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.	
High Impact Change Model for Managing Transfer of Care	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM as such, is included in this section.	Chg 1. Early Discharge Planning Chg 2. Systems to Monitor Patient Flow Chg 3. Multi-Disciplinary/Multi-Agency Discharge Teams Chg 4. Home First / Discharge to Access Chg 5. Seven-Day Services Chg 6. Trusted Assessors Chg 7. Focus on Choice Chg 8. Enhancing Health in Care Homes Other - 'Red Bag' scheme Other approaches
Home Care or Domiciliary Care	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.	
Housing Related Schemes	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.	

Integrated Care Planning and Navigation	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches like Single Point of Access (SPoA) and linking people to community assets. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams and the HICM for managing discharges, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.	Care Coordination Single Point of Access Care Planning, Assessment and Review Other
Intermediate Care Services	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.	Bed Based - Step Up/Down Rapid / Crisis Response Reablement/Rehabilitation Services Other

Personalised Budgeting and Commissioning	Various person centred approaches to commissioning and budgeting.	Personal Health Budgets Integrated Personalised Commissioning Direct Payments Other
Personalised Care at Home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.	
Prevention / Early Intervention	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.	Social Prescribing Risk Stratification Choice Policy Other
Residential Placements	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.	Supported Living Learning Disability Extra Care Care Home Nursing Home Other
Other	Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.	

^^ Link back up

7. High Impact Change Model

Maintaining system flow across Greater Nottingham from the acute Trust into community services continues to be a challenge. As a result, health and social care partners are committed to streamlining the urgent and emergency care hospital discharge planning to support system resilience. As a local health and social care system, it is recognised that the development of a 'Home First' approach to care will support the delivery of high quality patient care for the population. Local Health and Social Care partners over the last two years have been committed to develop the model of an Integrated Discharge Function (IDF). The IDF is a system wide integrated function that is community led with an overarching aim to ensure that all individuals are timely and effectively discharged or transferred from acute, health and social care settings to improve outcomes for individuals and support efficient flow through the Greater Nottingham services. The principle is patients are proactively managed from the time of admission to discharge to ensure patients do not wait, and their discharge is planned, timely and seamlessly managed between and across all providers. System partners have reviewed the progress made to date and have developed a system transformation plan to tackle key system issues utilising BCF schemes which includes but not limited to:

Leadership:

- Single function incorporating front door, back door, and community hub(s);
- Single leadership/accountability for function regardless of staff employment;
- Sustainability plan (permanent workforce);
- Investment in staff development (rotational training).

Process:

- One IDT process across all wards, early decision making, reduction of handoffs including to community, Lean work progressing. Streamline partner processes;
- Front door pathway re-mapped to link with acute frailty pathways;
- Re-design of community support services such as rehabilitation beds, rehabilitation at home and home care.

Performance:

- Rethink development of KPI's including access and time stamping of each part of the process;
- System ownership operational group reporting to Home first via Highlight report & performance vigour.

As result of this work we have updated our current maturity position for change 1, 3 & 4 with an aspiration of these change areas maturing to established by March 2020.

		Please enter current position of maturity	Please enter the maturity level planned to be reached by March 2020	If the planned maturity level for 2019/20 is below established, please state reasons behind that?
Chg 1	**Early discharge planning**	Plans in place	Established	
Chg 2	**Systems to monitor patient flow**	Established	Established	
Chg 3	**Multi-disciplinary/Multi-agency discharge teams**	Plans in place	Established	
Chg 4	**Home first / discharge to assess**	Plans in place	Established	
Chg 5	**Seven-day service**	Established	Established	
Chg 6	**Trusted assessors**	Established	Established	
Chg 7	**Focus on choice**	Established	Established	
Chg 8	**Enhancing health in care homes**	Established	Established	

Better Care Fund 2019/20 Template

8. Metrics

Selected Health and Wellbeing Board: Nottingham

8.1 Non-Elective Admissions

	19/20 Plan	Overview Narrative	
Total number of specific acute non-elective spells per 100,000 population	**Collection of the NEA metric plans via this template is not required** as the BCF NEA metric plans are based on the NEA CCG Operating plans submitted via SDCS.	To help address the growth of NEL admissions, a transformational piece of work on Population Health is being developed by the Integrated Care System. In order to review the long term conditions focus, the ICS are reviewing a significant amount of data to determine what the Nottingham and Nottinghamshire population looks like, what interventions are required and the risks involved. The outcome will be shared with locality teams, to help Primary Care Networks to understand, support and manage their local populations.	**Please set out the overall plan in the HWB area for reducing Non-Elective Admissions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

Plans are yet to be finalised and signed-off so are subject to change; **for the latest version of the NEA CCG operating plans at your HWB footprint please contact your local Better Care Manager (BCM)** in the first instance or write in to the support inbox:
ENGLAND.bettercaresupport@nhs.net

8.2 Delayed Transfers of Care

	19/20 Plan	Overview Narrative	
Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	33.3	Following a commissioned diagnostic system review of DTOC, led by Newton Europe on behalf the national partners of the Integration and Better Care Fund, the outcome and recommendations were shared with the Greater Nottingham Urgent Care Team in summer 2018. The recommendations have been embedded as part of localised plans, with workstreams in place to monitor and address performance. There are a number of key actions that are currently being taken to improve the performance of this metric, namely: • A review of CCG commissioned interim homecare services	**Please set out the overall plan in the HWB area for reducing Delayed Transfers of Care to meet expectations set for your area. This should include any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric. Include in this, your agreed plan for using the Winter Pressures grant funding to support the local health and care system to manage demand pressures on the NHS, with particular reference to seasonal winter pressures.**

Please note that the plan figure for Greater Manchester has been combined, for HWBs in Greater Manchester please comment on individuals HWBs rather than Greater Manchester as a whole.

Please note that due to the merger of Bournemouth, Christchurch and Poole to a new Local Authority will mean that planning information from 2018/19 will not reflect the present geographies.

8.3 Residential Admissions

		18/19 Plan	19/20 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	1,021	982	Nottingham's Adult Social Care Strategy Better Lives, Better Outcomes (BLBO) sets a clear intention to shift from use of residential care to community based support as part of its drive to promote independence and help people at home where possible. It commits to move to a position where no one will live in residential care unless
	Numerator	390	380	
	Denominator	38,200	38,706	

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

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2016 based Sub-National Population Projections for Local Authorities in England;

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

8.4 Reablement

		18/19 Plan	19/20 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.0%	80.0%	The Reablement Service provides short period of intensive reabling homecare support help people to regain skills and confidence following a hospital admission or period of illness. This service has a positive impact on this metric by helping people to redevelop their capacity to continue to live safely at home. Through the delivery of the
	Numerator	724	724	
	Denominator	905	905	

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

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

Better Care Fund 2019/20 Template

9. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Nottingham

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	**Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted?** Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Do the governance arrangements described support collaboration and integrated care? Where the strategic narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure, metric and HICM sections of the plan been submitted for each HWB concerned?	Yes			
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that covers:** - Person centred care, including approaches to delivering joint assessments, promoting choice, independence and personalised care? - A clear approach at HWB level for integrating services that supports the overall approach to integrated care and confirmation that the approach supports delivery at the interface between health and social care? - A description of how the local BCF plan and other integration plans e.g. STP/ICSs align? - Is there a description of how the plan will contribute to reducing health inequalities (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics under the Equality Act 2010? This should include confirmation that equality impacts of the local BCF plan have been considered, a description of local priorities related to health inequality and equality that the BCF plan will contribute to addressing. Has the plan summarised any changes from the previous planning period? And noted (where appropriate) any lessons learnt?	Yes			
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home. In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Yes			
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Yes			
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Yes			
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	**Is there a plan for implementing the High Impact Change Model for managing transfers of care?**	**Does the BCF plan demonstrate a continued plan in place for implementing the High Impact Change Model for Managing Transfers of Care?** Has the area confirmed the current level of implementation and the planned level at March 2020 for all eight changes? Is there an accompanying overall narrative setting out the priorities and approach for ongoing implementation of the HICM? Does the level of ambition set out for implementing the HICM changes correspond to performance challenges in the system? If the current level of implementation is below established for any of the HICM changes, has the plan included a clear explanation and set of actions towards establishing the change as soon as possible in 2019-20?	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Have the planned schemes been assigned to the metrics they are aiming to make an impact on? Expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (tick-box) Is there an agreed plan for use of the Winter Pressures grant that sets out how the money will be used to address expected demand pressures on the Health system over Winter? **Has funding for the following from the CCG contribution been identified for the area?** - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Yes			
	PR8	**Indication of outputs for specified scheme types**	Has the area set out the outputs corresponding to the planned scheme types (Note that this is only for where any of the specified set of scheme types requiring outputs are planned)? (auto-validated)	Yes			
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric? Is there a proportionate range of scheme types and spend included in the expenditure section of the plan to support delivery of the metric ambitions for each of the metrics? Do the narrative plans for each metric set out clear and ambitious approaches to delivering improvements? **Have stretching metrics been agreed locally for:** - Metric 2: Long term admission to residential and nursing care homes - Metric 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement	Yes			