Integrated Care System
Nottingham & Nottinghamshire

2023 - 2025 Better Care Fund Narrative Plan

Nottingham City HWB
Nottinghamshire County HWB

v1.0 28/06/2023

Integrated Care System
Nottingham & Nottinghamshire

Contents

Integrated Care System
Nottingham & Nottinghamshire

Section 1

Our ICS approach

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Nottingham & Nottinghamshire

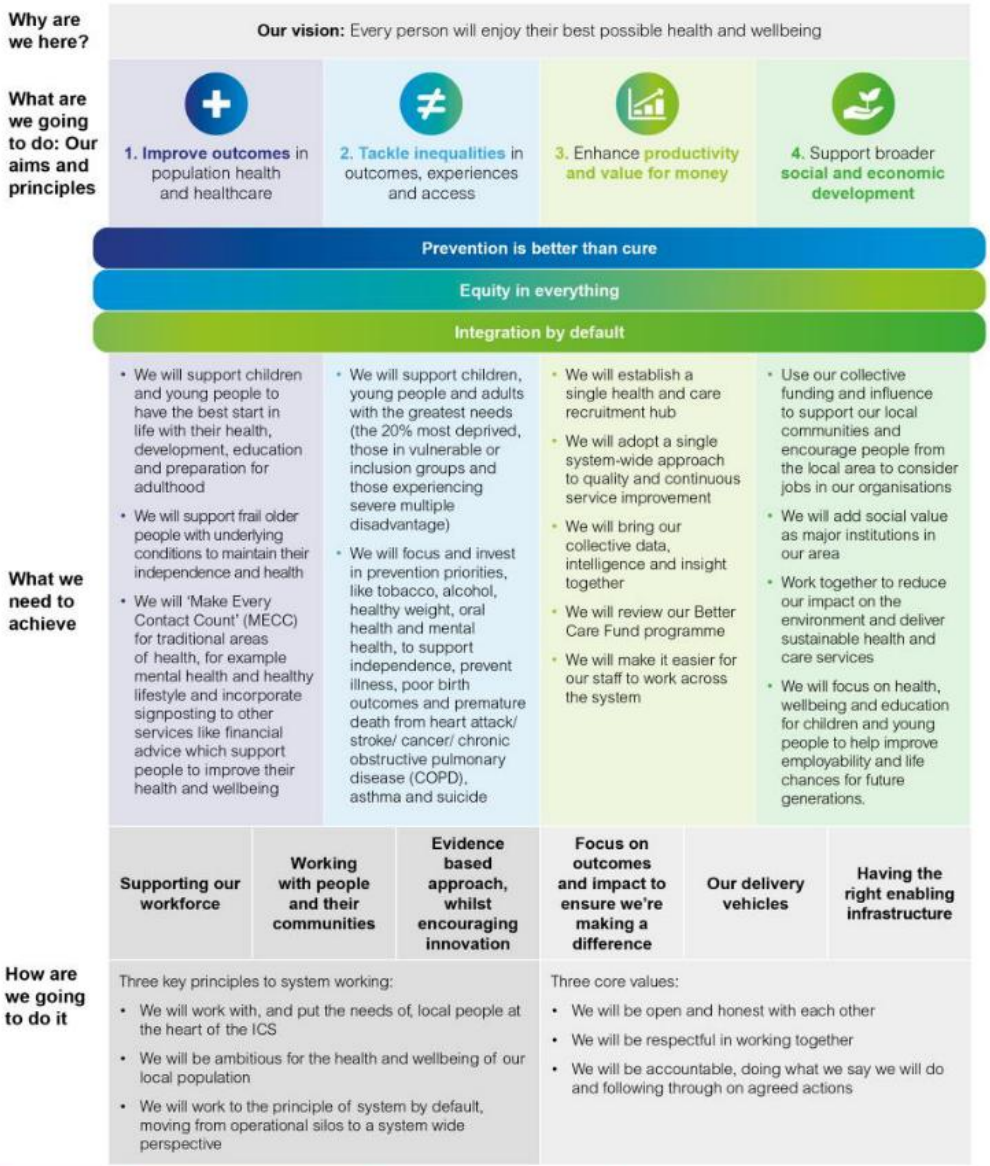
Our Integrated Care Strategy was agreed by the system in March 2023, and sets out our strategic aims for 2023-28.

1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience and access
3. Enhance productivity and value for money
4. Support broader social and economic development

The Strategy is based on three guiding principles:

1. Prevention is better than cure
2. Equity in everything
3. Integration by default

The BCF is a key component of our strategy and we will continue with our review to enhance collaborative commissioning of BCF schemes.



How the 2023 -25 BCF supports delivery of our ICS Vision

ICS Vision

Our neighbourhoods, places and system will seamlessly integrate to provide joined up care. Every citizen will enjoy their best possible health and wellbeing

BCF objective

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Priority work areas

- **Ageing Well** Anticipatory Care Model
- **Living Well** Prevention, maximising independence and 'early help'
- **Urgent Care** Discharge to Assess and Transfer of Care Hubs

Enabling System programmes

- **Community Transformation**
- **System development**
- **Data insight and interoperability**

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Aim of the Better Care Fund

The Better Care Fund (BCF) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care .

The ICS is committed to drive collaboration, innovation and integration through the BCF plans.

There are two joint plans: one agreed by Nottingham and Nottinghamshire Integrated Care Board (ICB) and Nottingham City Council; and one agreed by Nottingham and Nottinghamshire Integrated Care Board (ICB) and Nottinghamshire County Council. The plans are owned by the Health and Wellbeing Boards (HWBs) and governed by an agreement under section 75 of the NHS Act (2006).

The national conditions for the BCF 2023 -25 are:

- Jointly agreed plan between local health and social care signed off by the health and wellbeing board.
- NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution
- Invest in NHS commissioned out-of-hospital services
- Implementing the BCF policy objectives:
    - Enable people to stay well, safe and independent at home for longer
    - Provide the right care in the right place at the right time.

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Our Collaborative Planning and Commissioning Framework

VISION

To deliver **Integrated Health and Care** within the ICS, joining up strategic leadership and the transformation of health and care to improve outcomes for our population, ensuring decision making is led and integrated at the appropriate population level, with an emphasis on subsidiarity.

PRINCIPLES

Why we are taking this approach

- We will deliver improved outcomes and reduce health inequalities, driven by an understanding of the needs of our population
- We will optimise the use of our collective resource by reducing duplication, moving away from services commissioned and delivered in silos, making it easier for people to access the right support or care to meet their needs
- We will enable providers to work collaboratively to deliver improved quality and efficiencies

What we will do together

- We will work with our population to ensure they are involved in decision making at all stages of planning and delivery
- We will work as health and care partners, considering the opportunities for person centred integrated delivery for every decision we make
- We will focus on early intervention and prevention to support people to avoid increasing levels of support / cost
- We will use the best available evidence to support our decision making

How we will work

- Our Place Based Partnerships will drive our integrated health and care approach, bring together the planning and delivery of integrated care
- We will have transparency in our decision making, sharing financial and outcomes information to reach a collective decision
- We will hold ourselves accountable for working to these principles and for the delivery of integrated health and care, recognising the statutory responsibilities of each partner

VALUES

- We will be open and honest with each other
- We will be respectful in working together
- We will be accountable, doing what we say we will do and following through on agreed actions

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Section 2

Reviewing the 22/23 BCF plan

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2022/23 BCF Plan Review

During 22/23 we completed a Root and Branch Review of the BCF. This review is a key component to developing our future system-wide collaborative commissioning approach in order to maximise opportunities for collaborative commissioning, pooled resources and the delivery of integrated services to improve outcomes for the population and achieve best value for money.

The aim of the root and branch review was to understand how we can better use the BCF as a vehicle to join up health and care services across a wide range of services such as public health, support for unpaid carers, housing support and community initiatives.

The initial review findings have highlighted the potential of the BCF to drive our system ambitions for integration and enable us to achieve the three principles set out in the Integrated Care Strategy:

1. Prevention is better than cure
2. Equity is everything
3. Integration by default

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2022/23 BCF Plan Review

The review made specific recommendations to identify opportunities for greater collaboration in the following areas:

Early Help and Prevention

Integration of lifestyle reaching health inclusion advice services (e.g. smoking, alcohol and weight management support) with health and care pathways e.g. delivery of smoking cessation services in partnership with maternity services

Maximising the effectiveness of a range of developing navigation and support worker roles e.g. social prescribing, navigators, community workers, health coaches).

Proactive Care

Integration of MDT case management and development of PCN Neighbourhood teams e.g. health, social care, housing and VCS input (frailty, falls and wider complexities e.g. substance misuse and mental health.

Outcome and impact monitoring and our ability to plan demand and capacity for admission avoidance

Discharge to Assess

Integration of housing support, adaptation and temporary accommodation

Ability to meet complexity of need at home (P1)

P2 and P3 bed commissioning review (including MH flow)

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Learning Laboratories

A series of 'learning laboratories' took place in 22/23 bringing together partners to explore how different commissioners and providers can work together on specific integration projects. The laboratories were a mix of system-wide and place-based issues and were designed to explore what the barriers and enablers are to this collaborative approach.

The key findings were:

- the importance of a shared vision and understanding
- that a greater focus on prevention is needed
- there are challenges around identifying appropriate scope and focus (place/system).

The learning from these laboratories is informing our BCF plans as we continue to explore areas for increased collaboration.

As a system Nottingham and Nottinghamshire are committed to a greater emphasis on prevention, as evidenced in our new ICS strategy.

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Section 3

Governance and system engagement

Governance of our 2023 - 25 BCF plans

The **City Health and Wellbeing Board** has delegated responsibility for the BCF to the Health and Wellbeing Board Commissioning Sub-Committee.
The Sub-Committee is jointly chaired by Nottingham City Council and Nottingham and Nottinghamshire ICB.

The **Nottinghamshire County Health and Wellbeing Board** is responsible for oversight of the BCF.

An **ICS BCF Oversight Group** meets quarterly to oversee planning and performance for the BCF. The group has representatives from commissioning, finance and transformation workstreams from the ICB and both local authorities. This group jointly plans and creates the BCF plan with input from wider commissioners and programmes. Expenditure and scheme level plans are produced at HWB level.

System engagement and oversight of BCF Plans

A "Collaborative Commissioning Oversight Group" (CCOG) has been established to provide ongoing leadership for new ways of commissioning. The is group is a collaboration of NHS and Local Authority commissioners. As well as providing leadership and co-ordination for specific areas of collaborative commissioning, the group will inform system development priorities, including the development of integrated delivery approaches at Place.

CCOG will provide the strategic steer to the BCF Oversight Group, supporting the development of a 23-25 BCF Plan and ensuring this reflects changes to commissioned services and collective oversight of resources and outcomes.

Wider partners including Providers, Local Authority service leads and the third sector are engaged in the plan at scheme level. The schemes which comprise the Additional Discharge Fund have specific system –wide oversight from the **ICS Operational Discharge Steering Group** and through that group to the **Ageing Well Board**. Work will continue to develop collaborative commissioning approaches to Place Based Partnerships during 23-25 with the BCF as a key enabler to integration

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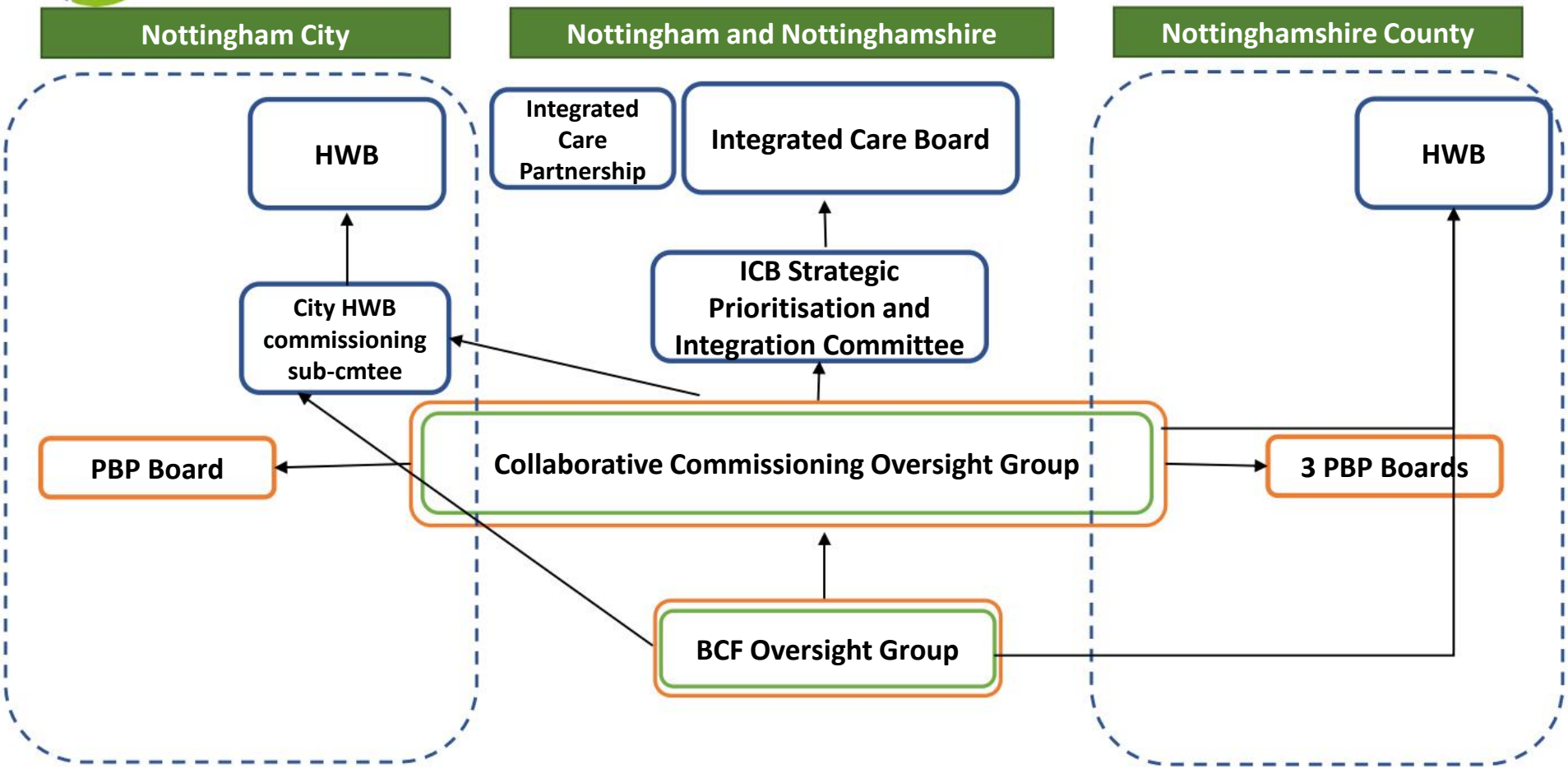
Collaborative Commissioning Governance

This slide shows the governance and oversight which aligns development of integrated delivery at Place and strategic oversight to commissioning



Advisory | Statutory | Partnership

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Section 4

BCF Plans 2023 - 25

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Developing our BCF plans for 2023 - 25

The 2023-25 BCF Plan provides our structured approach to joint planning between ICB and Local Authority. The BCF provides a vehicle to join up health and care services with wide ranging services such as public health, support for unpaid carers, housing support and community initiatives. These cover a range of evidence based commissioned services, provisions and intentions (as per SCIE logic model Logic model for integrated care | SCIE). Locally, we have agreed to describe these in our BCF plan under the following three themes:

Prevention and early intervention services: e.g. healthy lifestyle support, single point of access and support to navigate services, supported self-care

Anticipatory Care Services e.g. care co-ordination and multi-agency assessment and care planning, homecare and reablement, urgent care / crisis response, housing and assistive technology, primary care enhanced services
Discharge to assess services: integrated discharge teams, community beds, interim placements, homecare, reablement, housing support schemes.

Our BCF planning approach has been strengthened through the joint planning required to agree the Additional Discharge Funding, which linked BCF planning to our ICS –wide urgent care forums and reported through to our Ageing Well Board. We will continue to work with our developing Place Based Partnerships to realise the potential for BCF to support effective integrated service delivery and improved community wellbeing at Place and neighbourhood level, supported by BCF system oversight.

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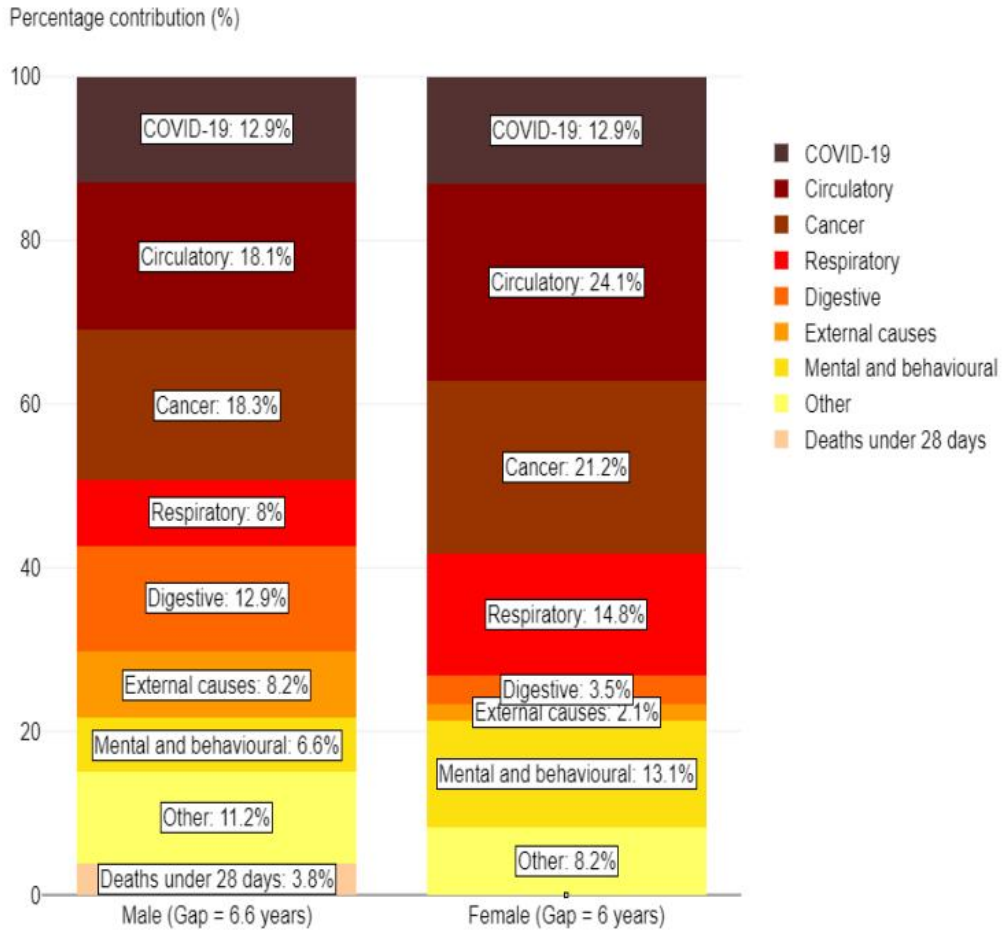
Accelerating our Health Inequalities Approach



Within our ICS, people in the most deprived areas have a life expectancy of around 6-7 years lower and spent 14 years longer in poorer health than those in the least deprived areas. Circulatory diseases (CVD), Cancer and Respiratory Conditions are some of the leading causes for this gap in life expectancy, disproportionately affecting people in more deprived areas and in many cases can be preventable.

Smoking rates are higher in the most deprived areas of the ICS, with Mansfield having the 3rd highest smoking rates in England. Smoking can increase the risk of CVD, Respiratory Conditions and Cancer.

Circulatory diseases (CVD) are the largest cause of life expectancy gap in the ICS with hypertension being the largest modifiable risk factor in its development. Obesity, diet and lifestyle factors can increase the risk of hypertension which is also more prevalent in areas of high deprivation and is also a key clinical area in the Core20Plus5 approach. Preventive lifestyle interventions could reduce the risk of hypertension and CVD development in the most at risk populations

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Nottingham & Nottinghamshire

Accelerating our Health Inequalities Approach

- **The Core20Plus5 Approach** to tackling health inequalities underpins the NHS approach to tackling health inequalities across the ICS. The approach focuses on improving outcomes for the 20% most deprived populations across the ICS as well as "plus" populations identified as having some of the worst health outcomes. These are the groups which should be considered foremost when service planning to help reduce health inequalities. This targeted approach can be taken at all points of the care model, including prevention, proactive care and discharge to access services.
- Building an equitable health and care system is also a key approach taken by the ICS to reduce health inequalities. This includes delegating resources to areas where the need is the greatest or taking different more flexible approaches when considering access to services for different populations. This can be considered when addressing early help and prevention needs as well as proactive care.
- Over 40% of the population aged 65 and over in Nottingham City are classed as living in an area with high deprivation. Higher deprivation is associated to higher morbidity and lower life expectancy. People living in more deprived areas of Nottinghamshire are also more likely to report having a disability or life limiting illness. Disabled people are more likely to live in poverty, have less access to education and employment, and experience poorer ratings of personal wellbeing compared with non-disabled people. People with disabilities may also struggle to have their voices heard within services and may require more flexibility from the health and care system in order to access services. Where this flexibility is not available, it can impact on access and experience of care and result in people not receiving the care they need.
- Use of urgent and emergency care for Long Term Condition management is more common in areas of higher deprivation, and people in the most deprived quintiles have increased rates of multi-morbidity compared with those in the least deprived deciles. Anticipatory care will benefit these cohorts by providing targeted proactive and personalised care to help improve quality of life and condition management, aiming to reduce the need for hospitalisations.
- Carers are twice as likely to suffer from poor health compared to the general population, primarily due to a lack of information and support, finance concerns, stress and social isolation. Young carers feel say they feel invisible and often in distress, with up to 40% reporting mental health problems arising from their experience of caring.

Integrated Care System
Nottingham & Nottinghamshire

Priority area 1: Early Help and Prevention

Prevention, as defined in the Care Act Statutory Guidance (2016), is about **the care and support system actively promoting independence and wellbeing**. This means intervening early to support individuals, helping people retain their skills and confidence, and preventing need or delaying deterioration wherever possible

Priorities for 2023 - 24 include how lifestyle advice services could be more integrated with health and care pathways, and also how to maximise the effectiveness of a range of navigation and support worker roles. We'll look to maximise opportunities to support strength based and personalised approaches across health and social care to support independence, wellbeing and to prevent ill health.

Our 2023 - 25 areas of focus within the BCF plan include the procurement of new services to support unpaid Carers in line with the new joint strategy, plus early intervention, access to advice, information and coordinated support. This recognises the benefit brought by the Health and Wellbeing Board strategy to focus on the wider determinants on improving health and wellbeing through community focused approaches.

Priority area 1: Early Intervention and Prevention: Our Support to Unpaid Carers

Support to unpaid carers is a priority area of collaborative commissioning which will increase early intervention and improve services. The system completed the ICS Carers strategy in 22/23, a key achievement which was jointly developed between Nottingham City and Nottinghamshire Councils, ICB and co-produced with Carers, Providers and VCSE. The strategy is hinged on 10 key components developed by carers, and 'I' statements have been formulated to describe what good looks like. In response, partner organisations have developed 'we' statements to say what they should be doing in order to make sure carers needs are met. The carers support services that form part of our BCF plans support the implementation of the strategy.

Identification and early support

Vision: Carers should be identified and offered support at the earliest opportunity ie. At the point of diagnosis/discharge

'I' statements	'We' statement	BCF support
• I want to be able to access information and support when I need it • I would like support at first contact to understand my situation • I would like help to understand what a carer is	• We will work together with key partners across the system to identify carers and provide signposting and support. This will include GP practices, schools, healthcare providers (including hospitals) and care providers	• Carers hub in place City/County provide information & signposting to carers. • In 23/24 single hub to be commissioned ensuring consistent service offer across the ICS. Hub will be commissioned to support GP practices to identify carers. • Young carer specific service giving advice/signposting & support to understand their

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Nottingham & Nottinghamshire

Priority area 1: Early Intervention and Prevention: Our Support to Unpaid Carers

Carers will continue to be involved in overseeing the implementation of the strategy. This piece of work has also laid the foundation for the approach to collaborative commissioning moving forwards. The strategy will provide guidance and structure to the collaborative commissioning and procurement of high quality carers services during 23/24 which are designed to respond to the 'I' statements. We are also working with our places to ensure that carer support is tailored to our diverse populations. This will lead to improved outcomes for carers, increased return on investment and opportunities to increase early intervention and integration across health and care. We will embed the changes and monitoring of these new services in our BCF Plans.

Scope of Services to Support Unpaid Carers

Carers Hub – a single point of access for information and advice. This will include assessment and support planning

- Education, training and engagement with schools, employers and health and care professionals

Carers respite- to provide breaks from caring with a flexible offer to include home based breaks and residential breaks.

Young Carers Service- information, advice, support and activities.

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Priority area 1: Prevention and Early Intervention Schemes

Nottingham City	
Early Intervention	*Scheme ID 2 Care Navigation and Planning* *Scheme ID 13 Carers, Advice and support, respite service* *Plus embedded early intervention and prevention approaches across delivery of adult social care schemes (note some scheme/spend shown in 2- Ageing Well – anticipatory care model)* *Integration of community connections, Primary Care Networks and support roles e.g. social prescribing*

Nottinghamshire County	
Early Intervention	*Scheme ID 12 Carers Short Breaks* *Scheme ID 19 Carers respite* *Scheme ID 21 Carer Advice and Support* *Scheme ID 22 'Supporting People'* *Scheme ID 27 Enabling Care Act statutory responsibilities* *Plus embedded early intervention and prevention approaches across delivery of adult social care schemes (note some scheme/spend shown in 2- Ageing Well – anticipatory care model)* *Integration of community connections, Primary Care Networks and support roles e.g. social prescribing*

Integrated Care System
Nottingham & Nottinghamshire

Priority area 2: Proactive Care model

As a system we are committed to developing our preventative approach to ensuring frail older people receive the right care, at the right time, in the right place. Across 5 PCN pilot sites, we are testing and developing our proactive approach to moderate and severely frail people, by focussing primary care led MDT's on reaching out to this population and having a personalised conversation in line with the national operating framework for Proactive Care. We know that all communities are different, and we are ensuring that our model is reflective of our communities. We are doing so in line with the PHM data that informs us of the key health and social care risks for each community to ensure its an evidence based preventative conversation. We are engaging with all key stakeholders to ensure they are part of our single neighbourhood level team who will be working with this population anyway.

The plan is to evaluate the pilots, understand the early indicators of success, as we know prevention doesn't yield a reduction in emergency admissions immediately, in order to inform our 23/24 priority areas.

In Nottingham and Nottinghamshire, Urgent Community Response (UCR) providers respond to both level one and level two falls (as per the Association of Ambulance Chief Executives definition). Moving forwards, the ambition it to expand upon the direct referrals into UCR from Care Homes as well as Technology Enabled Care (TEC) providers. This is expected to divert demand away from the ambulance service and into UCR, resulting in more patients who have fallen being managed in their own home, or usual place of residence, as opposed to a hospital admission.

Integrated Care System
Nottingham & Nottinghamshire

Priority area 2: Proactive Care model

Additionally, in 23/24 work will be undertaken locally to:

- Review the existing falls prevention and management interventions and pathways
- Development of evidence-based strength and balance provision
- Targeted support to care homes
- Upskilling the clinical workforce
- Developing integration between UCR and the EMAS Community First Responder model
- Systems plans to establish a Frailty admission avoidance virtual ward in 23/24

We have a system wide approach to addressing health inequalities and a **really strong foundation of data through our Strategic Analytics and Information Unit** which is operational across the ICB. We can demonstrate that we know where each of our PHM target cohorts reside, the risk factors and link with touchpoints for NHS services. We are working hard as a system to expand this out into social care data too.

This work continues to be informed by the **Community transformation work during 23/24** – increase integration between health and care services at Primary Care Network level, this programme is enabling strong partnerships and improved relationships by connecting commissioned delivery with local communities and joint delivery models with VCS organisations to enable joined up care that is connected to local communities.

Priority area 2: Disabled Facilities Grant and Housing Integration

In 2023/24, the ICB and LA are supporting Housing Teams and Acute Hospitals to refresh the Housing Hospital Discharge protocol in the light of Transfer of Care Hub implementation. This protocol provides a partnership commitment to early identification (before medically fit) and duty to refer in the hospital and response from housing teams to ensure prioritised MDT assessment of individual's needs. This should therefore avoid delays. Once refreshed and agreed we will include within our BCF Oversight governance and ensure monitoring and feedback loops are embedded through the Urgent Care system governance.
The protocol also ensures appropriate input during hospital stays for people with complex needs and that wraparound support is in place when people leave hospital e.g. specialist homelessness services.

We have two local joint housing schemes to support the BCF objectives. The two schemes have been developed by councils with significantly high levels of housing and health inequality and are an integral part of the Transfer of Care Hub team, providing a housing expertise and highly flexible problem-solving h to patients at risk of a housing related discharge delay. The team take on the communication with housing assessment and arrange rapid housing interventions and provide support to the patient and their family to support them through housing change

Disabled Facilities Grant is recognised across Nottinghamshire as playing a vital role in creating safe and suitable home environments that prevent falls and other incidents in the home, promote independence and minimise care requirements. The need for strategic drive and oversight has been recognised and a new Adaptation for Independence Strategic Oversight Group has been established. This group aims, with the support of Foundations, to build collaborative working, use data to inform planning and evidence impact. A key priority for partners in 2023-24 is to consider financial challenges, within a county where districts and boroughs experience quite varying budget allocations, not proportionate to demand. A central framework agreement for the purchase of stairlifts will also require review in 2023-24.

Integrated Care System
Nottingham & Nottinghamshire

Priority area 2: Proactive Care Schemes

(note historic scheme labelling means that City and County expenditure can not be compared on a scheme by scheme basis)

Nottingham City	
Care Coordination and Navigation	*Scheme ID 1 – CityCare 'Out of Hospital Contract' MDT, LTC case management, specialist nurses and NCGPA Social Prescribing*
Primary Care Enhanced Services	*Scheme ID 7- GP Practice enhanced services for case management, MDT and coordination with specialist teams*
Urgent Care/2 hr Crisis	*Scheme ID 3 – CityCare 'Out of Hospital Contract' 2hour response service*
Housing & Tech	*Scheme ID 10,11,12- Assistive Technology – telehealth, dispersed alarms, equipment* *Scheme ID 14 – Housing Health – Hospital to Home, supporting prevention and D2A* *Scheme ID 15- Disabled Facilities Grant*
Nottinghamshire County	
Care Coordination and Navigation	*Scheme ID 5 and 8 NHT South Notts/Mid Notts case management, MDTs and specialist nursing)*
Primary Care Enhanced Services	*Scheme ID 4 – GP Practice enhanced services for case management, MDT and coordination with specialist teams* *Scheme ID 20 Care Home Quality*
Urgent Care	*Scheme ID 6 British red cross 2 hour response* *Scheme ID 7 South Notts NHT 2 hour response* *Scheme ID 11 Evening and night nursing* *Scheme ID 13 ED Front Door and streaming (SFHT acute)*
Housing & Tech	*Scheme ID 26 – Disabled Facilities Grant* *Scheme ID 24- Supported accommodation younger adults* *Scheme ID 25 Direct Payments for older and younger adults*

Integrated Care System
Nottingham & Nottinghamshire

Priority area 3: Our Discharge to Assess model

Plans for improving discharge and ensuring that people get the right care in the right place:

At the heart of our D2A model is the ethos of 'home first' aiming to reduce the risks associated with patients who are medically safe remaining in an acute hospital any longer than necessary once they are medically safe for transfer (MSFT). D2A is comprised of three pathways: Pathway 1 (P1) – discharge home with reablement, Pathway 2 (P2) – discharge to bedded facility for reablement prior to discharge home and Pathway 3 (P3) – discharge to bedded facility for reablement and assessment for potential long-term care placement.

During 2023-24 we will continue to invest in and transform our P1 offer and are working towards integrating health and social care teams to provide the support patients need at home after hospital discharge. This will improve patient outcomes by reducing time spent in hospital, providing earlier reablement and rehabilitation to maximise functional outcome and reduce demand on long-term homecare and placements. We will continue to invest in the developing Transfer of Care Hubs, which will be fully embedded by 2024-25 ensuring that capacity is increased so that there is 7 day working across the P1 offer and that this is in place before winter. We are also planning to review current mental health support in community to work alongside the P1 model to support frail patients, including those with dementia and delirium. Work is ongoing to transform P2 and P3 to right size capacity and reduce length of stay in existing beds, the P2 and P3 transformed offer will be mobilised in 2024/5.

Integrated Care System
Nottingham & Nottinghamshire

Priority area 3: Our Discharge to Assess model

As a system we continue to develop and embed progress against the **High Impact Change Model** themes identified from ICS "What Good Looks Like" workshop held 8th September 2022. These themes are system data, culture change, embedding the discharge to assess approach of "Home First "and integration. Progress in 22/23 includes implementation of three multi-agency Transfer of Care Hubs built on Trusted Assessor principles, significant investment into Pathway 1 capacity across Health and Social Care to enable more people to go "Home First", ongoing development of an ICS D2A "One Version of the Truth" data set starting with the Transfer of Care Hubs and system wide workshops and rolling programmes of work to embed culture change and integration.

Collaborative Commissioning Progress: A collaborative commissioning review in 2022/23 resulted in a system wide agreement to a pooled funding investment for additional capacity across services to support improve delivery of the 'Pathway 1' integrated business case. This additional resource continues to be a system priority this year and is supported by a joint service specification, shared data monitoring and performance oversight. This is being supported by the ICS System Analytic Insight Unit and a single Urgent Care dashboard is in development. During 2023-25 we will continue to prioritise P1 across the system and model capacity accordingly.

Priority area 3: Our Approach to Capacity and Demand Modelling to Support Discharge from Hospital

Learning from 2022/23:

During 2022/23 there was an ambition to increase P1 capacity to a level where 300 P1 discharges could be made each week. P1 capacity has increased and allowed us to make progress towards this ambition but further work will still be required in 2023/24 to achieve this.

As the P1 capacity is still growing there were instances where P2 beds or P1 interim beds had to be used as an alternative. Work will continue into 2023/24 to increase P1 capacity to ensure the ideal pathway is followed.

Delays in P1 reablement services have significantly reduced in the second half of 2022/23. There has also been a reduction in the average length of stay for P2 beds, and we have been able to decommission a number of interim beds too.

Approach to estimating demand, assumptions made and gaps in provision identified:

The direction of travel will be to continue to increase P1 capacity in order to reduce delays in the discharge pathway and reduce unnecessary transfers to a Pathway 2 bed or interim bed.

The demand and capacity plans support our aims of increasing Pathway 1 capacity to reduce delays, improve flow and right size capacity across the ICS. This is reflected in the wider BCF plans.

Our available datasets do not clearly differentiate between rehabilitation and reablement at this point in time, therefore for the purposes of the BCF plan all Pathway 1 activity is assigned to reablement and all Pathway 2 activity is assigned to rehabilitation. Capacity planning has taken into account bed base, caseload and the number of hours of care provided per person. Phasing has been split into equal 1/12ths as last years data shows a relatively stable monthly pattern throughout the year for discharges.

Integrated Care System
Nottingham & Nottinghamshire

Priority area 3: Our Discharge to Assess schemes

(note historic scheme labelling means that City and County expenditure can not be compared on a scheme by scheme basis)

Nottingham City	
Integrated Discharge Team	*Scheme ID 4, 8,9- Facilitating Discharge, integrated enablement teams and supporting D2A. Mental Health integrated discharge*
Rehab/reablement	*Scheme ID 4, 6- reablement, rehabilitation and homecare provision.*
Community beds	*Scheme ID 4 City Care 'out of hospital' contract community beds*
Housing	*Scheme ID 15 Hospital to Home – housing advice to D2A, minor adaptations and 'handyperson' type support.*

Nottinghamshire County	
Integrated Discharge Team	*Scheme ID 3 Support to Integrated Discharge planning* *Scheme ID 15 Bassetlaw Mental health discharge roles* *Scheme ID 16,17, 18 Bassetlaw Discharge and assessment teams (across acute, mental health and community)*
Rehab/reablement	*Scheme ID 1- Short term rehab (NHT lot 10 South Notts)* *Scheme ID 9 and 10- Falls Prevention (NHT Mid Notts Community Rehab falls and South Notts East Bridgford Falls Rehab)*
Community beds	*Scheme ID 2- Community beds (NHT Lot 8- South Notts Lingsbar and Mid Notts Fernwood)* *Scheme ID 23- Nursing and dementia interim placement*
Housing	*Housing support to D2A 'ASSIST' under review*

Integrated Care System
Nottingham & Nottinghamshire

Priority area 3: Additional Discharge Funding

In 2022/23 Adult Social Care Discharge Funding was made available to ICS's to build in additional adult social care and community based reablement capacity, to facilitate timely discharges from hospital during the peak winter period. The system used this opportunity in a number of ways including increasing bedded capacity and resourcing recruitment initiatives across care pathways.

In 2023-24 Additional Discharge funding is again being provided to enable local areas to build additional adult social care and community-based reablement capacity to reduce delayed discharges and improve outcomes for patients. The total funds of £4.335m for Nottinghamshire County Council and £2.328m for Nottingham City Council and £5.710m for the Integrated Care Board. There is a requirement that the ICB expenditure of the funding is agreed with the relevant Health and Wellbeing Board, and the population-based methodology has been applied to apportion the funding as in 2022/23.

The system used the learning from the 2022-23 schemes and stakeholders have taken the collective view to continue to fund those schemes which added capacity during 2022/23 and had a proven impact upon discharge. This includes a particular focus on Pathway 1 as an agreed system priority; Nottingham City has significantly improved it's discharge position for P1 waits in 2022/23 as a result of last years winter discharge funding. The proposal for 2023/24 is to focus on P1 and seeks to continue to support and maintain the resilience created within the external homecare market which has resulted in waits for P1 discharge being maintained in single figures since march 2023. Nottinghamshire are also committed to a resilient P1 pathway and are also proposing using the fund to add resilience to the broader workforce.

Robust governance of the Additional Discharge Funding is provided through the Ageing Well Board with regular oversight and impact monitoring to be provided via the ICS Operational Discharge Group moving forwards.

Integrated Care System
Nottingham & Nottinghamshire

Priority area 3: Our Additional Discharge Schemes

Please see slide 32 for the rationale behind the schemes for each HWB

Nottingham City	
Integrated neighbourhood services	*Scheme 28 Urgent Community Response*
Rehab/reablement at home to support discharge	*Scheme 27 & 29 Pathway 1 discharge programme*

Nottinghamshire	
Integrated neighbourhood services	*Scheme 35 Urgent Care Community Response*
Reablement at home to support discharge	*Scheme 34 Pathway 1 discharge programme*
Reduce delayed discharges supporting the principles of D2A	*Scheme 36 additional staffing capacity*
Planning services in advance and enabling providers to recruit to their workforce	*Scheme 37 Extended voluntary sector capacity, bespoke landing pages vacancies*
Additional capacity (learning from previous funding)	*Scheme 38 Mental health step up/down beds, surge homecare provision/bed capacity*
Improving collaboration and information sharing across health & social care	*Scheme 39 Mental Health Hospital Discharge Commissioner, Strategic system transformation posts, development integrated therapy training, development integrated working community health and social care reablement*

Integrated Care System
Nottingham & Nottinghamshire

Section 5

Summary of changes to 23/25 plan

Integrated Care System
Nottingham & Nottinghamshire

Summary of Changes to 23 -25 Plan

23-25 Change to Nottinghamshire County HWB BCF Plan

The Additional Discharge Funding (detailed on the previous slides) is an addition to the BCF plans this year.

Support for unpaid carers will be re-commissioned within 2023/24 and a new service across the ICS area will provide consistent service provision across City and County.

23 – 25 Changes to Nottingham City HWB BCF Plan

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Integrated Care System
Nottingham & Nottinghamshire

Appendix 1

Nottinghamshire – Personalised Commissioning £37 million

Protecting social care - £14,490,518
This is expected to meet an increase in demand for Direct Payments for Ageing Well and Living Well.

Ageing Well:
The anticipated increases comprise of home care provision to enable people to remain living independently at home, prevention of avoidable hospital admissions, and to reduce or delay admissions into long-term care home placements. Service users are allocated a personal budget in the form of a Direct Payment which they use to arrange and manage their own care and support packages.

Living Well:
There are considerable budget pressures arising from the increased demand for large complex packages of care to support people with learning disabilities to remain living in the community.

Improved Better Care Fund - £22,824,301
The IBCF has been used to contribute to funding care packages, the increase in the complexity of needs has been seen across the adult social care demographic. Community provision has meant more people require bespoke community provision to meet their needs, this has led to increases in gross package costs. Combined with annual inflationary increases this has led to increased budget pressures across adult social care. The IBCF has been used to help fund the increased pressures relating to both gross package increases and inflationary uplifts which has helped to sustain the adult social care market.