APPENDIX 1

Better Care Fund 2019/20 Template

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS

2. Cover

Version 1.2

Health and Wellbeing Board:	Nottinghamshire
Completed by:	Paul Brandreth
E-mail:	paul.brandreth@nottscc.gov.uk
Contact number:	0115 97 73856 or 07384 236 169
Who signed off the report on behalf of the Health and Wellbeing Board:	Melanie Brooks

Will the HWB sign-off the plan after the submission date?	Yes
If yes, please indicate the date when the HWB meeting is scheduled:	06/11/2019

	Role:	Professional Title (where applicable)	First-name:	Surname:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Steve	Vickers
	Clinical Commissioning Group Accountable Officer (Lead)		Amanda	Sullivan
	Additional Clinical Commissioning Group(s) Accountable Officers		Idris	Griffiths
	Local Authority Chief Executive		Anthony	May
	Local Authority Director of Adult Social Services (or equivalent)		Melanie	Brooks
	Better Care Fund Lead Official		Melanie	Brooks
	LA Section 151 Officer		Nigel	Stevenson
Please add further area contacts that you would wish to be included in official correspondence -->				

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete

	Complete:
2. Cover	Yes
4. Strategic Narrative	Yes
5. Income	Yes
6. Expenditure	Yes
7. HICM	Yes
8. Metrics	Yes
9. Planning Requirements	Yes

[<< Link to the Guidance sheet]

Checklist

2. Cover

^^ Link back to top

	Cell Reference	Checker
Health & Wellbeing Board	D13	Yes
Completed by:	D15	Yes
E-mail:	D17	Yes
Contact number:	D19	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	D21	Yes
Will the HWB sign-off the plan after the submission date?	D23	Yes
If yes, please indicate the date when the HWB meeting is scheduled:	D24	Yes
Area Assurance Contact Details - Role:	C27 : C36	Yes
Area Assurance Contact Details - First name:	F27 : F36	Yes
Area Assurance Contact Details - Surname:	G27 : G36	Yes
Area Assurance Contact Details - E-mail:	H27 : H36	Yes

Sheet Complete	Yes

4. Strategic Narrative

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Cell Reference	Checker

A) Person-centred outcomes:	B20	Yes
B) (i) Your approach to integrated services at HWB level (and neighbourhood where applicable):	B31	Yes
B) (ii) Your approach to integration with wider services (e.g. Housing):	B37	Yes
C) System level alignment:	B44	Yes

Sheet Complete	Yes

5. Income

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	Cell Reference	Checker
Are any additional LA Contributions being made in 2019/20?	C39	Yes
Additional Local Authority	B42 : B44	Yes
Additional LA Contribution	C42 : C44	Yes
Additional LA Contribution Narrative	D42 : D44	Yes
Are any additional CCG Contributions being made in 2019/20?	C59	Yes
Additional CCGs	B62 : B71	Yes
Additional CCG Contribution	C62 : C71	Yes
Additional CCG Contribution Narrative	D62 : D71	Yes

Sheet Complete	Yes

6. Expenditure

^^ Link back to top

	Cell Reference	Checker
Scheme ID:	B22 : B271	Yes
Scheme Name:	C22 : C271	Yes
Brief Description of Scheme:	D22 : D271	Yes
Scheme Type:	E22 : E271	Yes
Sub Types:	F22 : F271	Yes
Specify if scheme type is Other:	G22 : G271	Yes
Planned Output:	H22 : H271	Yes
Planned Output Unit Estimate:	I22 : I271	Yes
Impact: Non-Elective Admissions:	J22 : J271	Yes
Impact: Delayed Transfers of Care:	K22 : K271	Yes
Impact: Residential Admissions:	L22 : L271	Yes

Impact: Reablement:	M22 : M271	Yes
Area of Spend:	N22 : N271	Yes
Specify if area of spend is Other:	O22 : O271	Yes
Commissioner:	P22 : P271	Yes
Joint Commissioner %:	Q22 : Q271	Yes
Provider:	S22 : S271	Yes
Source of Funding:	T22 : T271	Yes
Expenditure:	U22 : U271	Yes
New/Existing Scheme:	V22 : V271	Yes

Sheet Complete	Yes

7. HICM

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	Cell Reference	Checker
Priorities for embedding elements of the HCIM for Managing Transfers of Care locally:	B11	Yes
Chg 1) Early discharge planning - Current Level:	D15	Yes
Chg 2) Systems to monitor patient flow - Current Level:	D16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Current Level:	D17	Yes
Chg 4) Home first / discharge to assess - Current Level:	D18	Yes
Chg 5) Seven-day service - Current Level:	D19	Yes
Chg 6) Trusted assessors - Current Level:	D20	Yes
Chg 7) Focus on choice - Current Level:	D21	Yes
Chg 8) Enhancing health in care homes - Current Level:	D22	Yes
Chg 1) Early discharge planning - Planned Level:	E15	Yes
Chg 2) Systems to monitor patient flow - Planned Level:	E16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Planned Level:	E17	Yes
Chg 4) Home first / discharge to assess - Planned Level:	E18	Yes
Chg 5) Seven-day service - Planned Level:	E19	Yes
Chg 6) Trusted assessors - Planned Level:	E20	Yes
Chg 7) Focus on choice - Planned Level:	E21	Yes
Chg 8) Enhancing health in care homes - Planned Level:	E22	Yes
Chg 1) Early discharge planning - Reasons:	F15	Yes
Chg 2) Systems to monitor patient flow - Reasons:	F16	Yes

Chg 3) Multi-disciplinary/Multi-agency discharge teams - Reasons:	F17	Yes
Chg 4) Home first / discharge to assess - Reasons:	F18	Yes
Chg 5) Seven-day service - Reasons:	F19	Yes
Chg 6) Trusted assessors - Reasons:	F20	Yes
Chg 7) Focus on choice - Reasons:	F21	Yes
Chg 8) Enhancing health in care homes - Reasons:	F22	Yes

Sheet Complete	Yes

8. Metrics

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	Cell Reference	Checker
Non-Elective Admissions: Overview Narrative:	E10	Yes
Delayed Transfers of Care: Overview Narrative:	E17	Yes
Residential Admissions Numerator:	F27	Yes
Residential Admissions: Overview Narrative:	G26	Yes
Reablement Numerator:	F39	Yes
Reablement Denominator:	F40	Yes
Reablement: Overview Narrative:	G38	Yes

Sheet Complete	Yes

9. Planning Requirements

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	Cell Reference	Checker
PR1: NC1: Jointly agreed plan - Plan to Meet	F8	Yes
PR2: NC1: Jointly agreed plan - Plan to Meet	F9	Yes
PR3: NC1: Jointly agreed plan - Plan to Meet	F10	Yes
PR4: NC2: Social Care Maintenance - Plan to Meet	F11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Plan to Meet	F12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Plan to Meet	F13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F15	Yes
PR9: Metrics - Plan to Meet	F16	Yes
PR1: NC1: Jointly agreed plan - Actions in place if not	H8	Yes

PR2: NC1: Jointly agreed plan - Actions in place if not	H9	Yes
PR3: NC1: Jointly agreed plan - Actions in place if not	H10	Yes
PR4: NC2: Social Care Maintenance - Actions in place if not	H11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Actions in place if not	H12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Actions in place if not	H13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H15	Yes
PR9: Metrics - Actions in place if not	H16	Yes
PR1: NC1: Jointly agreed plan - Timeframe if not met	I8	Yes
PR2: NC1: Jointly agreed plan - Timeframe if not met	I9	Yes
PR3: NC1: Jointly agreed plan - Timeframe if not met	I10	Yes
PR4: NC2: Social Care Maintenance - Timeframe if not met	I11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Timeframe if not met	I12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Timeframe if not met	I13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I15	Yes
PR9: Metrics - Timeframe if not met	I16	Yes

Sheet Complete	Yes

Better Care Fund 2019/20 Template

3. Summary

Selected Health and Wellbeing Board: Nottinghamshire

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£6,950,696	£6,950,696	£0
Minimum CCG Contribution	£55,259,670	£55,259,670	£0
iBCF	£26,484,159	£26,484,159	£0
Winter Pressures Grant	£3,527,070	£3,527,070	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	£92,221,595	£92,221,595	£0

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£15,703,231
Planned spend	£31,629,156

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£21,452,018
Planned spend	£21,452,018

Scheme Types

Assistive Technologies and Equipment	£20,000
Care Act Implementation Related Duties	£2,168,668
Carers Services	£1,809,777
Community Based Schemes	£12,869,371
DFG Related Schemes	£6,950,696
Enablers for Integration	£0
HICM for Managing Transfer of Care	£1,068,319
Home Care or Domiciliary Care	£0
Housing Related Schemes	£0
Integrated Care Planning and Navigation	£17,833,000
Intermediate Care Services	£750,125
Personalised Budgeting and Commissioning	£0
Personalised Care at Home	£0
Prevention / Early Intervention	£0
Residential Placements	£0
Other	£48,751,639
Total	£92,221,595

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	554.7701288

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 (%)	0.829568789

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

Better Care Fund 2019/20 Template

4. Strategic Narrative

Selected Health and Wellbeing Board:	Nottinghamshire

Please outline your approach towards integration of health & social care:

When providing your responses to the below sections, please highlight any learning from the previous planning round (2017-2019) and cover any priorities for reducing health inequalities under the Equality Act 2010.

Please note that there are 4 responses required below, for questions: A), B(i), B(ii) and C)

Link to B) (i)
Link to B) (ii)
Link to C)

A) Person-centred outcomes Your approach to integrating care around the person, this may include (but is not limited to):	
- Prevention and self-care - Promoting choice and independence	
Remaining Word Limit:	609

The Nottingham and Nottinghamshire Integrated Care System is one of the national 'accelerator' sites. It covers six CCGs, and a unitary and two-tier local government structure with a city council, and a county council with seven district councils. There are also two well established Health and Wellbeing Boards – city and county. Across Nottinghamshire there are 3 planning systems; Integrated Care System (ICS), Integrated Care Partnership (ICP) and organisational level. ICS Leadership of the Universal Personalised Care programme is driving a collaborative approach across health, social care, district/borough Council and voluntary sector to commit to integrated teamwork and person-centred care, which underpins a shared commitment to Home First approaches, Services supporting discharge are planned jointly and multi-disciplinary assessments are undertaken outside of hospital. Helping people to help themselves; helping people when they need it and resolving issues at the earliest point; maximising peoples independence are all key attributes.

Targeting resources to help avoid admissions or minimise the length of stay respects the wishes of citizens to receive care and support as close to home as possible. The relentless focus on delayed transfer of care is supported by collaborative operational and strategic approaches.

A therapy led approach is adopted; Social care Occupational Therapy staff are working with hospital OT staff sharing knowledge to reduce length of stay. Sustaining people within their homes is supported by the supply of aids and adaptations, assistive technology and where necessary adaptations to housing funded by a Disabled Facilities Grant.

Led by the Health & Wellbeing boards and guided by the production of Joint Strategic Needs Assessments, there is a shared understanding at system level of the wider determinants of health. Constructive conversations are held with all partners to maximise the resources to address inequalities. Deprivation is a strong driver of illness and poor levels of health and it is recognised that across the ICS deprivation varies dramatically, increasingly place-based approach is being deployed to address inequalities and to maximise the strengths and assets of the community. 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 an 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.

Social prescribing approaches, utilising link workers will be supported and supplemented by the various services commissioned by the local authorities. Better community connectiveness for people facing isolation is a priority. Providing the right provision without recourse to formal assessments requires a shared and aligned approach. The use of digital apps is being explored to offer greater choice for managing ones needs. This will help reduce demand for limited resources, including A &E attendance. Collaboration is also evident with a revised carers strategy and the development of a newly commissioned carers hub.

The number of Personal Health Budgets has increased to over 1,800. Completion of each of these adds to the shared skill base of health and social care staff identifying "what matters" to people and devising self-directed care plans. Front line staff are piloting joined up assessments and the learning from the Integrated Care Teams and Integrated Accelerator Pilot is being rolled out. Discussions are underway to enable staff in the Newark and Sherwood District to hot-desk in shared venues in Newark and Ollerton, in order to increase opportunities for information sharing and advice. Further roll out of integrated approaches beyond older adults' services is planned with the Physical Disabilities team covering Mansfield and Ashfield. This will explore how best to engage with the Integrated Care Team and the monthly GP multi-disciplinary meetings for citizens with complex health and social care needs.

Frontline staff have also been equipped with person centred tools to help them have healthy conversations with people. A guide to make the most of conversations has been drafted and will be used by the multi-disciplinary teams. The final version will be made widely available within Notts Help Yourself (the website for citizens support and advice).

Within the ICS systems there is a commitment to engagement and co-production. Experts with lived experience are bringing their knowledge in a wide variety of planning and operational situations. They have developed a key element of the quality audit process for homebased care and are actively involved with its implementation. Within the Bassetlaw ICP the commitment to embracing a wide and inclusive partnership is exemplified by the local CVS chairing the Board. The Bassetlaw Place Plan is well embedded and is based on supporting people to self-manage their care to the maximum of their ability, and that of their carers.

B) HWB level

(i) Your approach to integrated services at HWB level (and neighbourhood where applicable), this may include (but is not limited to):	
- Joint commissioning arrangements - Alignment with primary care services (including PCNs (Primary Care Networks)) - Alignment of services and the approach to partnership with the VCS (Voluntary and Community Sector)	^^ Li
Remaining Word Limit:	203

Nottinghamshire has three Integrated Care Partnerships (ICP).; South County, Mid-Nottinghamshire and Bassetlaw ICP. All three ICPs will bring together health and care providers and local commissioners to work together to improve services for their population, and to make sure that they are sustainable.

The commitment to a consistent population health management approach will build on the existing Primary Care Networks, made up of GP practices and community teams. They will identify care gaps and utilise evidence-based interventions. The next phase will involve joint prioritisation of resources, to avoid the duplication of commissioned services. This will also enable the proportionate targeting of resources to reduce health inequalities where this is evidenced based.

A system-wide care navigation model to access urgent clinical assessment to avoid hospitalisation will be developed, using the learning from the 'Call for Care' provision used in Bassetlaw will be supplemented by learning from another part of the system namely the utilisation of social care and health data and predictive analytics in use in mid-Notts.

A joint strategic commissioning programme is underway to develop alternative services that have an evidence base for reducing the use of residential care. This includes Housing with Care, Short-term assessment and reablement apartments and Assistive Technology.

Since the publication of Nottinghamshire's BCF Plan for 2017/19, the lessons learnt include:

- A review of current services in 2018/19 identified an over-reliance on a large community bed base to provide Intermediate Care and Reablement. The development of a new integrated service across health and social care which will rationalise the current 7 pathways into Intermediate Care and Reablement support services, to 3 core integrated pathways, thus improving patient/service user outcomes.

- The development of the Integrated Discharge Team (IDT) and an integrated MDT approach to discharge planning has consistently reduced DTOC levels. The monitoring of DTOCs now forms part of a system escalation processes. In order to embed the change and continue to reduce DTOCS, we are reviewing the IDT, with the aim of implementing a fully funded 7-day service in 2019/20.

- The OT and community sector workers in the First Point of Contact Team, and the closer working relationships between the Care Co-ordination Centre and Integrated Rapid Response Service, shows that integration and alignment has clear benefits to customers/patients and to staff who become more knowledgeable of the wider health and social offer.

- Optimising the opportunities for ICT interoperability to improve patient experience across the whole system. We are now at the vanguard of this nationally, supported by the County Council using BCF, in harmony with Connected Nottinghamshire.

Increasingly there is an appetite to align market management and market development activity. Joint audits using the skill set of healthcare and social care staff are routinely undertaken. Training for care home staff is delivered by one of the NHS providers ensuring a minimum of 85% are trained on the seven key warning signs that leads to patient deterioration.

The joint commissioning partnership, Integrated Community Equipment Loans service, (ICELs) provides a highly effective and timely response to discharge patients. The service is available 7 days per week and often provides same day provision to expedite the speediest return home. The partnership harnesses the expertise of the British Red Cross as the delivery agent. Other services have been commissioned to provide 7-day rapid response, including night time support.

Advocacy is commissioned jointly and delivers the statutory requirements for health and social care, there are opportunities to maximise the use of advocacy to ensure people in marginalised groups are supported and able to access health and social care with equity.

(ii) Your approach to integration with wider services (e.g. Housing), this should include:	
- Your approach to using the DFG to support the housing needs of people with disabilities or care needs. This should include any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the (Regulatory Reform Order 2002)	
Remaining Word Limit:	483

^^ Li

There is a renewed commitment from all statutory partners to maximise the use of the DFG and the use of technology enabled care. Chief Executive Officers of the District Councils and the Corporate Director of Adult Social Care have met and agreed principles for the transformation of the DFG.

A review of the current process was commissioned from consultants ARK and a detailed action plan is being developed. The challenges of aligning the policies and procurement practice across 7 Districts will be tackled, with the shared objective of maximising the independence of citizens. This will extend to the provision of Assistive Technology.

Every partner recognises that Assistive Technology will be a major enabler for delivering more choice and control for citizens, with less interventions. This approach will be supported by a key strategic partner, Connected Nottinghamshire. They are tasked with delivering transformation across the health and care system, including collaboration with IT and digital solutions. Their work provides more effective and efficient services.

Nottinghamshire County Council has developed a Housing Strategy for younger adults and a Strategy for Housing with Care, previously referred to as "Extra care". These strategies are based on detailed needs analysis and have been created in close collaboration with partners and by co-production.

For working age adults with care needs the emphasis is to only provide housing with support (commissioned by the Council) where it is really needed and to try and maximise peoples' abilities to live in general needs housing. A review of all existing supported living is underway and at each property the potential use of Assistive Technology is considered.

For Older adults the approach is to develop a range of housing options, some of which are commissioned as Housing with Care. Projects are coming on stream, with more planned. Technology is of course maximised and embedded in all new schemes.

C) System level alignment, for example this may include (but is not limited to):	
- How the BCF plan and other plans align to the wider integration landscape, such as STP/ICS plans - A brief description of joint governance arrangements for the BCF plan	^^ Li
Remaining Word Limit:	930

In Nottinghamshire there are two Integrated Care Systems that cover the same footprint as the local authority. Nottinghamshire ICs and South Yorkshire and Bassetlaw ICS.

The ICSs are the vehicles for delivering integration across primary and specialist care, physical and mental health and social care. The systems provide strong local leadership and seek to implement population health management approaches, whilst tackling the systemic challenges that face health and social care. There are three Integrated Care Partnerships accountable to the ICSs. (The Nottinghamshire ICS has an additional ICP coterminous with Nottingham City). It makes for a complex set of relationships, especially for agencies and partners that have cross cutting relationships e.g. EMAS, Nottingham University Hospital.

The strength of the Nottinghamshire Health and Well Being Board (HWB) is that it is uniquely aligned to the boundaries of the County Council and all the Districts and Boroughs. As a statutory body it has governance at member and Chief Executive Officer level. The HMB provides oversight and scrutiny for all planning and expenditure with respect to the BCF. It is chaired by a lead member from the County Council with a GP as deputy chair. The population health approach is supported by the substantial input from Public Health.

The BCF steering group, which reports to the HWB is constituted from all the statutory partners and develops the detailed planning and programme management. There exists a strong commitment from all partners to ensure the BCF conditions are met and that quality is professionally evaluated.

The principles and purpose of the BCF are complementary to the priorities across the ICSs. Activity to: reduce length of stay in hospital; to promote preventative and reabling services; to support the care providers and ensure sustainability of provision; promote personalised care; use of digital, ICT and assistive technology are all examples of completely aligned objectives.

The HWB receives and signs off JSNAs and this year they also approved the Market Position Statement. All relevant key strategies are presented to partners such as the Housing with Care, Housing with Support, Digital, Autism Strategy. The Board and the BCF steering group are therefore able to oversee implementation plans that impact on processes such as patient flows, discharge planning, use of DFGs, long term care admission. Individual schemes and changes to services will undertake Equality Impact Assessments to understand any potential positive or negative impact on people from protected characteristics groups and also to assess the potential impact on health inequalities. All partners have a stake in aligned these pathways for citizens. By sharing commissioning activity the challenges presented by delayed transfers of care, lack of supply in the market, workforce deficits can be tackled more successfully, with better outcomes. An area that we are continuing to develop and learn about, across the whole system, is interoperability. We are constantly striving to be best in class in delivering integrated systems that have tangible benefits for citizens for example in reduce length of stay in hospital and better experience of assessment processes. We are equipping every GP, every Social Worker and all relevant hospital staff with the means to share records and improve interventions. This is advancing to Predictive Analytics, whereby automated notices for possible support can be generated based on algorithms and risk stratification. This approach is completely consistent with the ambitions of the ICSs.

Better Care Fund 2019/20 Template

5. Income

Selected Health and Wellbeing Board:	Nottinghamshire

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Nottinghamshire	£6,950,696
DFG breakerdown for two-tier areas only (where applicable)	
Ashfield	£922,788
Bassetlaw	£1,167,487
Broxtowe	£867,198
Gedling	£1,048,082
Mansfield	£1,256,409
Newark and Sherwood	£1,021,695
Rushcliffe	£667,037
Total Minimum LA Contribution (exc iBCF)	**£6,950,696**

iBCF Contribution	Contribution
Nottinghamshire	£26,484,159
Total iBCF Contribution	**£26,484,159**

Winter Pressures Grant	Contribution
Nottinghamshire	£3,527,070
Total Winter Pressures Grant Contribution	**£3,527,070**

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 Mansfield and Ashfield CCG	£13,850,112
NHS Nottingham North and East CCG	£9,991,378
NHS Newark and Sherwood CCG	£8,844,060
NHS Bassetlaw CCG	£8,180,652
NHS Rushcliffe CCG	£7,717,620
NHS Nottingham West CCG	£6,675,848
Total Minimum CCG Contribution	**£55,259,670**

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	**£55,259,670**	

	2019/20
Total BCF Pooled Budget	**£92,221,595**

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: Nottinghamshire

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£6,950,696	£6,950,696	£0
Minimum CCG Contribution	£55,259,670	£55,259,670	£0
iBCF	£26,484,159	£26,484,159	£0
Winter Pressures Grant	£3,527,070	£3,527,070	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	£92,221,595	£92,221,595	**£0**

Required Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£15,703,231	£31,629,156	£0
Adult Social Care services spend from the minimum CCG allocations	£21,452,018	£21,452,018	£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	A. Seven Day Working	Seven Day working	Intermediate Care Services	Reablement/Rehabilitation Services		Hours of Care	50,000.0	Low	Low	High	High	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£750,125	Existing
2	B. Delayed Transfers of Care	Reablement services	Community Based Schemes					Low	High	Medium	Medium	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£5,734,809	Existing
3	C. Reducing non-elective admissions	Community Based Schemes	Other		Geriatrician input pre & post discharge			High	High	Medium	Medium	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£108,045	Existing
3	C. Reducing non-elective admissions	Community Based Schemes	Community Based Schemes					High	Medium	Medium	Medium	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,806,499	Existing
3	C. Reducing non-elective admissions	Community Based Schemes	Community Based Schemes					High	Medium	Medium	Medium	Community Health		CCG			CCG	Minimum CCG Contribution	£972,399	Existing
3	C. Reducing non-elective admissions	Community Based Schemes	Other		Pysychological medicine scheme			High	Low	Low	Low	Mental Health		CCG			CCG	Minimum CCG Contribution	£162,066	Existing
3	C. Reducing non-elective admissions	Community Based Schemes	Community Based Schemes					High	Medium	Medium	Medium	Other	Charity /Voluntary Sector	CCG			CCG	Minimum CCG Contribution	£1,502,897	Existing
3	C. Reducing non-elective admissions	Community Based Schemes	Community Based Schemes					High	Low	Low	Medium	Primary Care		CCG			CCG	Minimum CCG Contribution	£2,745,407	Existing
4	D. Support to social care	Personalised Care at Home	Carers Services	Respite Services				Medium	Medium	Medium	Medium	Other	Carers	CCG			CCG	Minimum CCG Contribution	£273,605	Existing
5	E. Enabling	Other	Other		Enabling			Low	Low	Low	Low	Other	Enabling	CCG			CCG	Minimum CCG Contribution	£434,107	Existing
6	F. Proactive care (community based)	Integrated care teams	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				High	Medium	Not applicable	Not applicable	Community Health		CCG			CCG	Minimum CCG Contribution	£10,938,445	Existing
6	F. Proactive care (community based)	Integrated care teams	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	Not applicable	Not applicable	Not applicable	Community Health		CCG			CCG	Minimum CCG Contribution	£857,566	Existing
6	F. Proactive care (community based)	Integrated care teams	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Low	Not applicable	Not applicable	Not applicable	Community Health		CCG			CCG	Minimum CCG Contribution	£122,956	Existing
6	F. Proactive care (hospital based)	Integrated care teams	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	High	Not applicable	Not applicable	Acute		CCG			CCG	Minimum CCG Contribution	£2,010,556	Existing

7	G. Patient and carer support	Personalised support/ care at home	Community Based Schemes					Low	Not applicable	Not applicable	Not applicable	Community Health		CCG			CCG	Minimum CCG Contribution	£77,360	Existing
7	G. Patient and carer support	Personalised support/ care at home	Carers Services	Respite Services				Medium	Not applicable	Not applicable	Not applicable	Primary Care		CCG			CCG	Minimum CCG Contribution	£180,356	Existing
8	H. Better Together Implementation	Other	Other		Assistive Technology			Medium	Not applicable	Not applicable	Not applicable	Other	Enabling	CCG			CCG	Minimum CCG Contribution	£87,658	Existing
9	I. 7 day access to services	7 day working	HICM for Managing Transfer of Care	Chg 5. Seven-Day Services				Medium	Medium	Medium	Low	Community Health		CCG			CCG	Minimum CCG Contribution	£1,068,319	Existing
10	J. Mental Health Liaison	Integrated care teams	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				High	Low	Low	Low	Mental Health		CCG			CCG	Minimum CCG Contribution	£466,430	Existing
11	K. Discharge / Assessment incl. Intermediate	Integrated care teams	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	High	Not applicable	Not applicable	Community Health		CCG			CCG	Minimum CCG Contribution	£2,906,603	Existing
11	K. Discharge / Assessment incl. Intermediate	Integrated care teams	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	High	Not applicable	Not applicable	Mental Health		CCG			CCG	Minimum CCG Contribution	£470,549	Existing
11	K. Discharge / Assessment incl. Intermediate	Integrated care teams	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	High	Not applicable	Not applicable	Acute		CCG			CCG	Minimum CCG Contribution	£59,895	Existing
12	L. Respite services	Support for carers	Carers Services	Carer Advice and Support				Low	Low	Medium	Medium	Community Health		CCG			CCG	Minimum CCG Contribution	£21,000	Existing
13	M. Improving Care Home quality	Improving healthcare services to care homes	Community Based Schemes					Medium	Medium	Medium	Medium	Other	Care Homes	CCG			CCG	Minimum CCG Contribution	£30,000	Existing
14	N. Telehealth	Assistive Technologies	Assistive Technologies and Equipment	Telecare				Low	Not applicable	Medium	Medium	Community Health		CCG			CCG	Minimum CCG Contribution	£20,000	Existing
15	O. Support for carers	Support for carers	Carers Services	Carer Advice and Support				Low	Low	Medium	Medium	Social Care		LA			Local Authority	Minimum CCG Contribution	£864,816	Existing
15	O. Support for carers	Support for carers	Carers Services	Respite Services				Low	Low	Medium	Medium	Social Care		LA			Local Authority	Minimum CCG Contribution	£470,000	Existing
16	P. Protecting social care	Protecting social care	Other		Protecting social care			Medium	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£17,948,534	Existing
17	Q. Disabled Facilities Grant	DFG Related Schemes	DFG Related Schemes	Other	Housing			Medium	Medium	Medium	Medium	Other	Housing	LA			Local Authority	DFG	£6,950,696	Existing
18	R. Enabling Care Act statutory responsibilities	Enabling Care Act statutory responsibilities and	Care Act Implementation Related Duties	Other	Enabling Care Act statutory responsibilities			Medium	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£2,168,668	Existing
19	S. Improved Better Care Fund	Improved Better Care Fund	Other		Improved Better Care Fund			Medium	High	High	High	Social Care		LA			Local Authority	iBCF	£26,484,159	Existing
20	T. Winter Pressure	Winter Pressure	Other		Winter Pressure			Medium	High	High	High	Social Care		LA			Local Authority	Winter Pressures Grant	£3,527,070	Existing

Better Care Fund 2019/20 Template

7. High Impact Change Model

Selected Health and Wellbeing Board:	Nottinghamshire

Explain your priorities for embedding elements of the High Impact Change Model for Managing Transfers of Care locally, including:

- Current performance issues to be addressed
- The changes that you are looking to embed further - including any changes in the context of commitments to reablement and Enhanced Health in Care Homes in the NHS Long-Term Plan
- Anticipated improvements from this work

COUNTYWIDE

The ICS have set up a demand & capacity workstream to bring together operational and ICT colleagues to design ways to share information about capacity and flow. Each system's Surge & Escalation plan details triggers for identifying increased demand and bottlenecks together with actions at each OPEL level. Social care has produced a demand and capacity function which has allowed the system to have sight of available resource.

The NECS Care Home Bed Tracker has been rolled out countywide; this provides new insight about car home bed availability to save time in planning discharges.

SOUTH

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.

MID NOTTS

The Home First Integrated Discharge (HFID) work stream has experienced delays in full implementation, so whilst early phases have gone live the project in its entirety and has not. A Head of HFID post has been recruited to create a senior operational lead with responsibility to drive through service improvements and cultural change. There is evidence that patients are not being referred to Social Care early enough, and that there are continuing instances of inappropriate discharge notices – to improve this and other discharge processes embedded at SFHFT a revised Discharge Policy has been approved and is being rolled out across Sherwood Forest Health Trust (SFHT).

The ICS have set up a capacity and flow workstream to bring together operational and ICT colleagues to design ways to share data and intelligence about capacity and flow. Internal bed modelling work has taken place at SFHT to provide a seasonal bed model requirement. The system's Surge & Escalation plan details triggers for identifying increased demand and bottlenecks together with actions for all system partners at each OPEL level. This plan forms part of the mid-Notts system-wide Winter Plan which has been signed off by A&E Delivery Board and has been received by both the ICP and ICS Boards. Social care has produced a demand and capacity function which has allowed the system to have sight of available resource.

Social Care are attending the SFHT discharge hub and the Home First Response Service is in place. The NECS Care Home Bed Tracker which is being embedded at SFHFT and the Trusted Assessor post which is being considered as part of the Intensive Rapid Response Service (IRRS) work stream, will also provide additional insight and support to existing collaborative working nature of the Mid-Notts system.

There continues to be no appetite within local Social Care functions for the utilisation of a single trusted assessment form, or for health to assess on behalf of Social Care, but partners continue to review opportunities to streamline working processes. Some health organisations assess on behalf of other health

organisations e.g. IDAT for CFC and vice versa. On this basis Mid Notts is unlikely to be in a position to commit to achieving Mature or Exemplary. However, it is acknowledged that revised guidance around the HICM criteria will soon be available and this position will be re-considered if the expectations of the indicator change.

Patient Choice is a strong focus within the SFHT discharge policy and operationally, joint conversations take place between Health and Social Care teams when interim care is offered. The recent DToC guidance change to the Social Care categorisation of declined interim placements where homecare provision is not available, will ensure that the relevant organisation is enabled to impact upon these delays. Funding has been agreed to appoint a second Age UK Advocacy worker, who will increase the capacity for patients to have independent support when needed to take discharge actions. Care Home admissions continue to be low as per the target for mid-Nottinghamshire. A sustained portfolio of health services supports this cohort of providers, including the Acute Home Visiting Service, Significant Seven and 111. The 111 service will go live with offering the Call for Care Non-injury Falls Pathway to patients - previously this has only been available to EMAS, which will reduce unwarranted urgent care system activity and offer greater support to care homes. SFHT are part of the Frailty network and a work stream is in place to strategically address frailty from A&E throughout patient flow areas and to amalgamate all projects which will impact on frailty e.g. Clinical Navigators using e-Healthscope in General Practice to identify patients with severe, moderate and rising risks of frailty. Notts Healthcare Trust Proactive Care Homes & NEMs colleagues have undertaken RESPECT training and processes. Bi-monthly meetings between the EoL Head of Service and the CCG Care Homes Lead take place to ensure alignment of work programmes.

The mid-Nottinghamshire A&E Delivery Board has a workplan for 19/20 which incorporates the board's priorities for delivery. The EHCH framework is an indicator within the plan, along with the combined action plan to reduce LoS and DToCs.

BASSETLAW

Bassetlaw 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, the development of a 'Home First' approach to care supports the delivery of high quality, patient care for the population. This is recognised in the establishment of a new Bassetlaw task and finish group to review the current Home first pathways to ensure and develop the optimum approach to best serve the local population. There is already an embedded trusted assessor model in place with the hospital Integrated Discharge team but there are plans to extend this approach to the front end of the hospital within the Emergency Department to ensure efficient triage for individuals enabling the right service at the right time in the right place. The principle is patients are proactively managed from the time of initial triage through to admission and on to discharge to ensure patients do not wait, and their discharge is planned, timely and seamlessly managed between and across all providers. System processes are reviewed via 'System Perfect' weeks which enable robust reviews of hospital pathways from admission to discharge, where action plans are formed with all partners to resolve any highlighted key barriers to the patient journey.

- Redesign of Intermediate Care services linked to hospital discharge with a wrap round service providing patients with the right service at the right time in the right place via assessment apartments, home rehabilitation and community rehabilitation beds.

- Redesign of Emergency Department front door hospital services, developing a trusted assessor concept which would include a Frailty assessment linked to joined up Home first approach; to reduce hospital admissions, providing more efficient signposting to alternative services enabling people who present

at the emergency department to self-support.

- Further development of the Interoperability project to increase information sharing between hospital staff from the wards to the integrated discharge team, aiding efficiency in a patient's journey to timely hospital discharge.

		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: Nottinghamshire

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.	SOUTH When constructing the CCG operating plan, Nottingham University Hospitals declared some significant coding and counting changes which resulted in the Trust adding 15,000 additional zero length of stay non-elective spells to reflect the impact of the pathway changes at the A&E front door. These planned substantial increases in activity have yet to materialize and further work is planned to attain a better understanding of whether the lower numbers are due to lower demand, higher achievement against Quality, Innovation, Productivity and Prevention (QIPP) plans, or a lower level of coding and counting changes. Several projects and schemes are in place to assist with admission avoidance. These include care co-ordination which aims to deliver the foundations of a consistent approach to Population Health Management across the Greater Nottingham footprint. This project will build on the existing Primary Care Networks made up of groups of GP practices and community teams to embed a consistent care co-ordination approach to admission avoidance to identify care gaps and utilize evidence-based interventions. Schemes in place include: • Ensuring Network Navigators are fully focused on the identification of potential end-of-life patients as part of the GP Multi-Disciplinary Teams, and • Increasing levels of training for care home staff on the seven key early warning signs that lead to patient deterioration. Ensuring a minimum of 85% are trained in each targeted care home in a shorter timeframe.

		• A scheme focusing on high intensity users is also underway; the aim is to target patients who are frequent attenders to urgent care services. This will focus on three main categories of patients – frailty, long-term conditions, and mental health/alcohol – and will encompass social prescribing, care gap analysis as well as health coaching in some locality areas. MID-NOTTS Work is taking place across both mid-Notts and the Integrated Care System (ICS) to reduce activity at the front door, via the Drivers of Demand work stream, for example via the East Midlands Ambulance Service (EMAS) non-conveyance group, the Proactive Care Homes Service, High Intensity User Service and the Acute Home Visiting service. A focus on frailty continues in 2019/20 and Commissioning Leads are working closely with GP practices to ensure appropriate patients are identified and have care plans in place to reduce the risk of admission to hospital. Conversations are taking place with wider system partners to understand the holistic system response to frailty, for example via NEMS and EMAS. The End of Life service is now live and providing an alternative pathway for ambulance crews. The new IRRS (Integrated Rapid Response Service) will be mobilised in October 2019 and this will target both a reduction in ED attendance and a reduction in non-elective admissions. The mid-Notts CCGs review levels of high activity at individual practice level and manage with practices as appropriate. QIPP schemes are monitored closely and additional schemes are developed where possible. This has included extending the current chronic obstructive pulmonary disease (COPD) scheme to include further groups of patients and a scheme which will proactively manage those at risk of deterioration in care homes ('Significant7'). The mid Notts CCGs are working with ICS colleagues to commission an integrated urgent care pathway in 2019/20 which will include an integrated out of hours and clinical assessment service (CAS). This will ensure that more 111 calls receive clinical assessment, reducing the number of Emergency Department (ED) and ambulance dispositions.

		The A&E Delivery Board has agreed a work plan for 2019/20 which includes the national urgent and emergency care (UEC) deliverables as well as local priorities to manage demand. A seasonal plan has been developed, acknowledging the pressure on system providers all year and learning has been assimilated into this plan from last summer and winter periods. BASSETLAW: The CCG has invested considerably for this year's emergency / unplanned activity both in the hospital and to introduce the Call for Care model for Bassetlaw and to utilize health and social care data/predictive analytics tools already used in Mid and South Nottinghamshire. The CCG will continue to work with all partners to try and minimize the increase in activity.

8.2 Delayed Transfers of Care

	19/20 Plan	Overview Narrative
Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	39.0	BCF funded hospital-based Social Workers, Integrated Care Teams, integrated patient/service user information systems, Home First and reablement services (START) have all made a positive contribution to reducing or eliminating delays for social care reasons, which are now consistently close to zero and comfortably below target. A&E Delivery Boards have a lead role in managing DToCs for health reasons and Greater Notts are reporting that performance is in line with the NHS target of delays below 3.5% of monthly occupied bed days – which is at odds with the BCF indicator, where DToCs for health reasons are consistently above target. An ongoing issue with monitoring of DToCs is the conflicting method of calculating DToCs between NHSE/I and BCF. The Winter Pressures Grant has been targeted at services at the interface between health and social care and will increase the system's resilience through the seasonal period of increased demand. Areas of deployment include: - Additional OT capacity within reablement services

		- Additional roles within reablement services to help develop service user's independence - Additional SW and CCO capacity within community mental health teams to support earlier discharge planning - Increased numbers of commissioned Home First packages of care to enable timely discharge SOUTH The integrated discharge team at NUH is being re-developed into an integrated discharge function to increase capacity, activity, productivity and flow. This will be completed by winter 2019/20. MID-NOTTS There is now a Sherwood Forest Hospital Trust (SFHT) owned combined Length of Stay (LoS) & DToC action plan in place. This is part of the Accident and Emergency Delivery Board (A&EDB) workplan and the Board has signed-off the plan and will be monitoring progress from now onwards. • The Divisional General Manager for Medicine at SFHT, the Head of Nursing for Medicine and a lead Consultant undertake a Long Stay review of patients every week – this meeting also looks at DToCs and they are now shifting their focus from patients with a stay over 21+ days to 14+ days. • A system review of the SFHT discharge policy has been undertaken with a focus on Home First and addressing some of the blocks previously in place such as issuing 'Letter 1' on day 1 of a family looking for care homes instead of issuing on day 7. • SFHT and CCG colleagues DToC review meetings are in place. • The DToC & LoS action plan is made up of several internal and system-wide improvement work streams which will contribute to the overall improvements. • SFHFT colleagues have identified a new 7-day discharges work stream which will increase discharges during weekend periods, resulting in marginal gains for DToC reductions. • CCG colleagues have met with Notts CC and have undertaken a sit visit to the Notts county-wide equipment provider. Conversations are now taking place to identify how learnings from this visit can be embedded into operational process improvements within HFID. • Revised OPEL escalation triggers for SFHT now

		include DToC levels. . This will ensure that DToCs are aligned to business as usual processes and flow and ensure focus on blockages. • A new senior Home First lead has been appointed to drive the workstream and a dashboard of Key Performance Indicators (which include DToCs) has been created. • Transformation funding has now been received which will provide a discharge route out of the acute trust for non-weight bearing (NWB) patients, who currently contribute to DToC levels in mid-Notts. The remainder of the funding will go towards expediting the start dates of process improvement work streams for example, IRRS which will contribute to DToC rates by offering alternatives to admission. BASSETLAW Bassetlaw Hospital's share of the total DToC position has decreased significantly over the past year. The Integrated Discharge Team will continue to work with County Council colleagues and community care providers to ensure delays are kept to a minimum, and the Bassetlaw Call for Care service went live on the 29th July. Call for Care is the urgent care navigation service commissioned to deliver a two-hour response for people in Bassetlaw to prevent an avoidable hospital admission or support timely discharge from the Emergency Department.

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	558	555	Admissions into long-term care are avoided where possible through peer review and approval of placements by Team Managers/Group Managers to ensure that all alternative options to promote the person's independence have been explored. A Strategic Commissioning Programme is underway to develop alternative services that have an evidence base for reducing the use of residential care. This includes Housing with Care, Short Term Assessment and Reablement Apartments and Assistive Technology.
	Numerator	950	960	
	Denominator	170,230	173,045	

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 (%)	85.0%	83.0%	Last year's performance averaged at 80% so meeting this refreshed target will be challenging but should be achievable; actions put in place have already delivered significant improvement. Performance varies by the type of service and complexity of needs of the people using it: the START re-ablement team that supports people in their own homes achieved 89% last year, with accommodation based short term re-ablement for people with more complex needs having lower outcomes.
	Numerator	340	404	
	Denominator	400	487	

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9. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Nottinghamshire

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?
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