Planned BCF Schemes and Themes

Please note: *In addition to the schemes listed in this document, CCGs across Nottinghamshire are also working up further schemes to support the BCF outcomes and metrics that are not currently included in the pooled BCF arrangements. Further details can be found on the page 6 of this document, and in Part 1 of the plan.*

Theme	Schemes	Timescale for Delivery
1. 7 Day Service Provision and Access	**NORTH NOTTINGHAMSHIRE**	
	Intermediate Care Rapid Response – provides immediate support to people to avoid hospital admission	Year 1
	7 Day access to services – across GP and community providers to support hospital discharges	Year 1
	Mental Health Liaison – working 24/7 across the Bassetlaw hospital site	Year 1
	MID-NOTTINGHAMSHIRE	
	Primary care services: Care homes advanced nurse practitioner Improved primary care access - urgent primary care	Year 2
	SOUTH NOTTINGHAMSHIRE	
	7 day working - Develop a seven day offer of access to GP/community services	Year 2
	GP Access – work with the Urgent Care Board to develop access to Primary Care services	Year 2

Theme	Schemes	Timescale for Delivery
2. Supporting Integration	**NORTH NOTTINGHAMSHIRE**	
	Personalised care - Tailored care for vulnerable and older people – a comprehensive and co-ordinated package of care for patients over 75	Year 1
	Reablement Services – Independence and Reablement within the Hospital, enhanced Reablement services	Year 1
	Discharge/Assessment – multi agency single point of assessment for patients	Year 2
	MID-NOTTINGHAMSHIRE	
	Locality intermediate care teams - proactive care multi-disciplinary teams, low and enhanced intermediate care and the self-care hub. Virtual wards. Use of risk stratification tool to target high risk patients. Also includes care navigator - establishing a directory of services for health and social care to maintain people at home.	Year 1/2
	SOUTH NOTTINGHAMSHIRE	
	Personalised care - Tailored care for vulnerable and older people – a comprehensive and co-ordinated package of care for patients over 75	Year 2
	Community Geriatrician – Geriatric/Health Care of Older People provides comprehensive geriatric assessment in community settings, linking with primary care and community services in a planned approach. Consultant geriatricians provide expertise to multi-professional teams working with complex patients and provide case review and direct patient care with smooth access to secondary care as appropriate. Also provide education, training and mentorship for staff and advice to support the development of services. Supports a reduction in unnecessary hospital attendances	Year 2
	Community Hub Development – develop the GP/social care/mental health input to the Hub model	Year 2
	Community Programme – To meet people's needs as close to their normal residence as possible, by creating efficient, evidence-based health and social care systems which are perceived as seamless by patients, users and carers	Year 1/2
	Reablement services – additional social work posts and to develop reablement/intermediate care approaches to support the discharge of older people from hospital	Year 1/2

Theme	Schemes	Timescale for Delivery
3. Transforming Patient Satisfaction	**NORTH NOTTINGHAMSHIRE**	
	Respite Services – service users patient satisfaction	Year 1
	Improving Care Home Quality: - Overarching housing and care home strategy for older people - Care home residents risk stratification and lead clinicians for each home - Leadership training for care home sector - Workforce plan for care homes - Training programmes for care home staff	Year 1/2
	Telehealth – to support patients to manage their own care	Year 1
	MID-NOTTINGHAMSHIRE	
	Self-care service – dedicated and targeted support for patients to self-care and to identify the information and access to support services that they need to enable them to become more involved in their own care and maintain their well-being.	Year 2
	Communications (social marketing) –To enable local people to access appropriate services by identifying ways that can help them choose the right care at the right time, by specifically targeting resources to identified target groups.	Year 2
	SOUTH NOTTINGHAMSHIRE	
	Enhanced support to care homes - Community based, multi-disciplinary in-reach services (which compliments healthcare delivered by the GP) which proactively addresses the health needs of residents in residential and nursing care homes. Offering holistic assessment and timely responsive support to meet the health and end of life care needs of residents. Promoting improved collaborative working between the care home, primary care and community services. To deliver improved case management, that focuses attention away from reactive care, emergency call-outs and crisis management.	Year 2
	Support for Carers – provides carer support including short breaks, respite	Year 1
	Telehealth – to support patients to manage long term conditions through the 'Flo' Telehealth model	Year 2

Theme	Schemes	Timescale for Delivery
4. Protecting Social Care Services	**A range of county-wide schemes, including:**	
	Protecting social care services – Care for the elderly in the community - Intermediate care services reviewed and enhanced - Community model developed and implemented - Community nurse support to Primary Care - Review and enhance Community Matron model	Year 1/2
	Community Capacity - Rapid response (includes additional homecare) – to provide interim home care services to people in hospital awaiting discharge due to a delay in the start of their regular homecare services	Year 2
	Support to Social Care - Memory Assessment Service – supports social care input to early diagnosis for dementia scheme - Mental Health Intermediate Care Services - specialist intermediate care teams in each CCG for older people with Mental Health problems and dementia. - Advocacy services - Support to the Multi Agency Safeguarding Hub	Year 1/2
	Intermediate Care Bed Based – development of approach following new pilot at Gedling Village	Year 2

Theme	Schemes	Timescale for Delivery
5. Facilitating discharge	**NORTH NOTTINGHAMSHIRE**	
	Equipment Services – to support increased demand for equipment to support people to remain in their own home and to facilitate discharge	Year 1
	MID-NOTTINGHAMSHIRE	
	Specialist intermediate care team	Year 2
	SOUTH NOTTINGHAMSHIRE	
	Early Supported Discharge – work with NUH and community services to develop early discharge systems and approaches	Year 1
	Equipment Services – to support increased demand for equipment to support people to remain in their own home and to facilitate discharge	Year 1
	Home Care/Occupational Therapy – additional support for interim homecare, occupational therapy to support assessment	Year 1

Theme	Schemes	Timescale for Delivery
6. Infrastructure, Enablers and Other Developments	**A range of county-wide schemes, including:**	
	Developments to support the implementation of the Better Together scheme in Mid Nottinghamshire including: - Information management and technology - Organisational Development - Implementation support	Year 2
	Transformation Programme across South Nottinghamshire – to provide strong leadership across the South CCGs to lead the development of joint integration projects across Health and Social Care to oversee the strategic development and implementation of the integration agenda.	Year 2
	Disabilities Facilities Services - to support adaptations to dwellings occupied by disabled people	Year 2
	Other Projects to be fully developed and scoped	Year 2

Other Schemes Additionally Supporting BCF Outcomes and Metrics

An overview of additional schemes in place or under development, funded recurrently or non-recurrently in 14/15 in Nottingham North and East, Rushcliffe, and Nottingham West CCGs that will also support achievement of BCF outcomes and metrics.

Metric	Additional schemes that will be supporting achievement of BCF outcomes and metrics		
	NNE CCG	**Rushcliffe CCG**	**NW CCG**
Non-elective admissions (general and acute)	- GP Same Day/Urgent Care Pilot - First Responder Service in Community Hub - Care Home Community Model - Integrated Health and Social Care phase 1 – Adult Community Care Teams - Specialist Parkinson's Disease Nurse Service - Family Mosaic - Community 2	- Enhanced care home specification for general practice to go live 1st April 2014 - Enhanced care home support provided by CHP - Enhanced primary care service specification and proactive LTC management - Integrated adult care support from community services delivered through community wards - Phase 2 integration with social care and MHSOP	- Implement the national Direct Enhanced Service focussing on reducing avoidable admissions in the over 75s - Increase primary care rehabilitation service to educate care home staff to prevent falls - Actively target interventions and information e.g. promotion of the slips, trips and falls booklet, at areas identified in the rapid needs assessment as having poorest outcomes for older people - Proactive case management of LTC - expansion
	- Crisis response services - Electronic Palliative Care Co-ordination System (under development) - EMAS South Falls Service (underdevelopment)		
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	- Care Home Community Model provided by CHP - Family Mosaic - Community 2	- Enhanced care home specification for general practice to go live 1st April 2014 - Enhanced care home support provided by CHP	- Enhanced care home specification for general practice to go live 1st April 2014 - Enhanced care home support provided by CHP - Care Homes Pharmacist permanent
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital	- Integrated Health and Social Care phase 1 – Adult Community Care Teams	- Integrated adult care support from community services delivered through community wards	- 48 hour follow up for older people following an emergency admission - Expand the community ward multi-

into reablement / rehabilitation services	- Integrated Health and Social Care phase 2 – Social Care Integration - 48 hour follow up for older people following an emergency admission	- Phase 2 integration with social care and MHSOP - 48 hour follow up for older people following an emergency admission	disciplinary team to including social care and mental health support - Expand the scale and scope of the Retirement Living Integration Project with Broxtowe Borough Council and deliver the project plan
Delayed transfers of care from hospital per 100,000 population (average per month)	- GP Same Day/Urgent Care Pilot - First Responder Service in Community Hub - Care Home Community Model provided by CHP	- Integrated adult care support from community services delivered through community wards - Phase 2 integration with social care and MHSOP	- Enhanced care home support provided by CHP - Expand the community ward multi-disciplinary team to including social care and mental health support - Expansion of proactive care/case management models for LTC - Additional support for carers to support older people to remain at home
	- Care Coordination Team		
Patient, service user and carer experience (composite measure)	- PPE work across the CCG - CCG People's Council - GP Practice Patient Participation Groups - Family Mosaic - Community 2	- Patient Clinical Cabinet - Patient Active Group - Practice Participation Groups	- GP Practice Patient Participation Groups - Patient Reference Group - Events Planner - Deliver the agreed priorities of the Broxtowe Health Partnership Older Persons Sub group that focuses on ending loneliness, compassionate communities including inter-generation projects - Hold "carers weeks" road show events at least twice per year
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes directly from a hospital setting per 100 admissions of	- Integrated Health and Social Care phase 1 – Adult Community Care Teams - Care Home Community Model	- Integrated adult care support from community services delivered through community wards - Phase 2 integration with social care and MHSOP	- Enhanced care home specification for general practice to go live 1st April 2014 - Enhanced care home support provided by CHP

older people (aged 65 and over) to residential and nursing care homes (local metric)	- Chronic Care Management pilot - Care Home Community Model provided by CHP	- Enhanced care home specification for general practice to go live 1st April 2014 - Enhanced care home support provided by CHP	- Expand the existing services for long term conditions including education, psychological support and for people with long term neurological conditions - Additional support for carers to support older people to remain at home